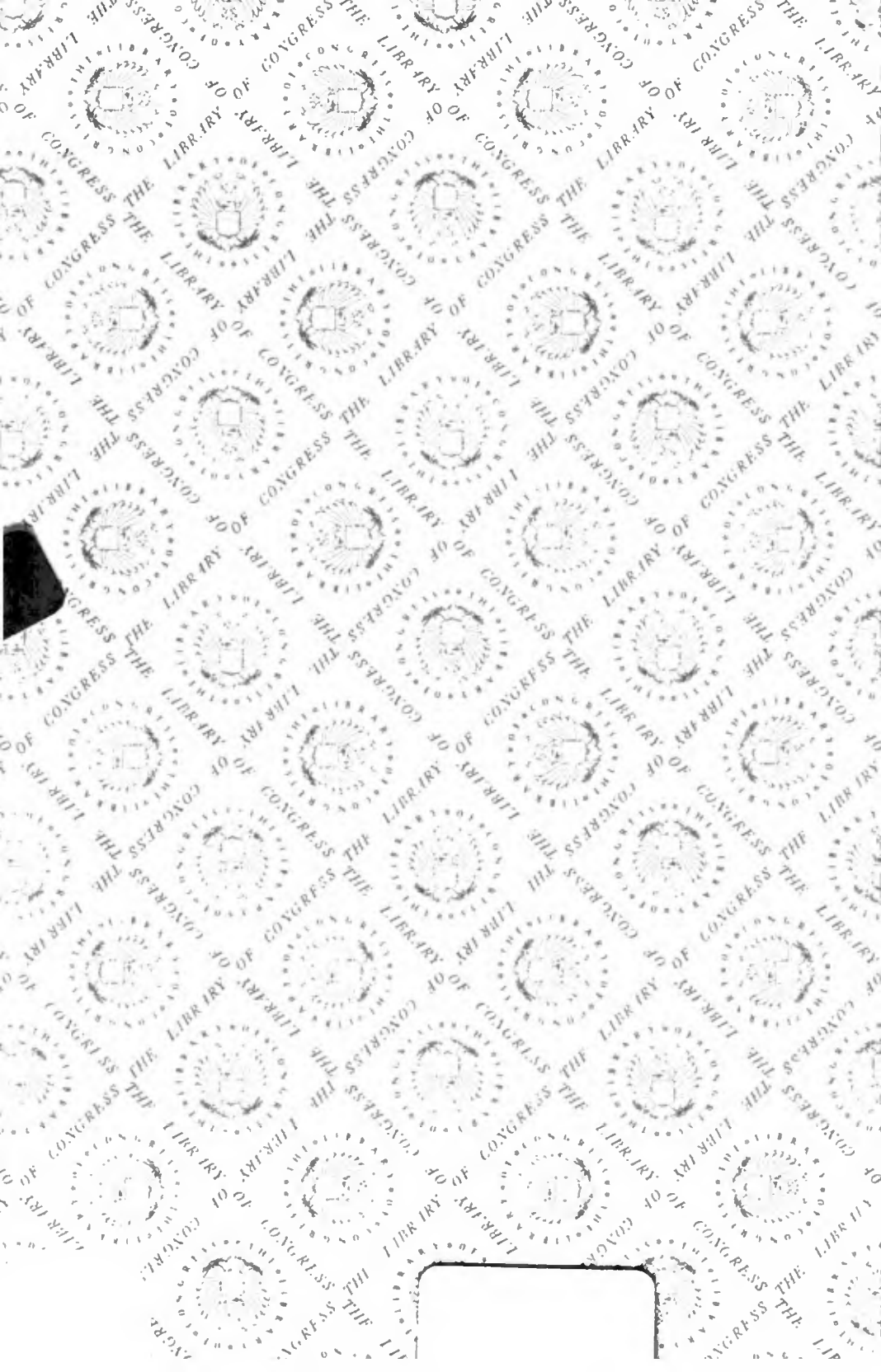

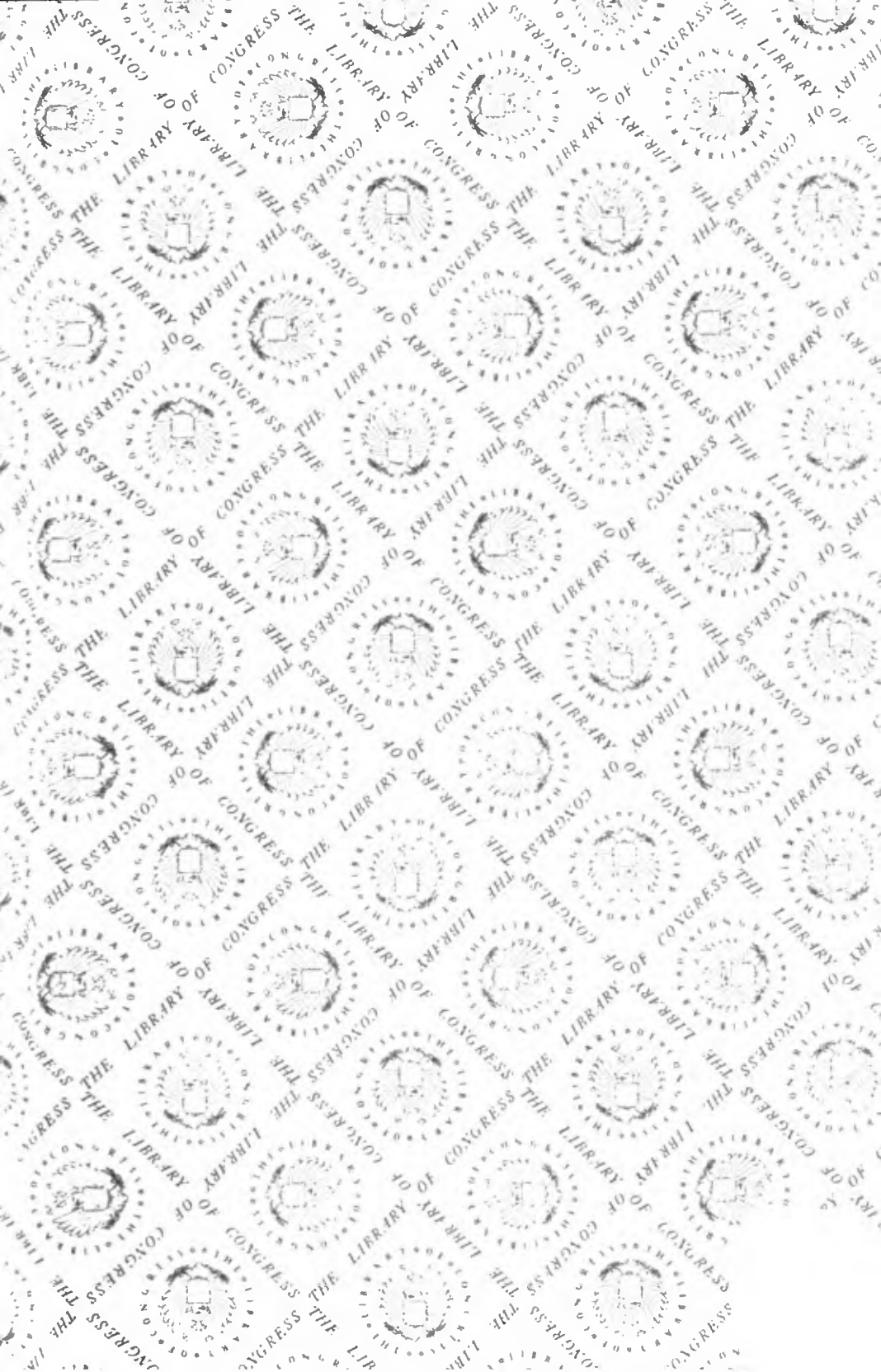
LIBRARY OF CONGRESS THE

OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

ON

H. Con. Res. 98, H. Con. Res. 119, and H. Con. Res. 149

HOUSE CONCURRENT RESOLUTIONS EXPRESSING THE SENSE OF CONGRESS IN OPPOSITION TO THE CLOSING OF PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

(And Similar Resolutions)

MARCH 5, 9, 10, 11, 12, 1971

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OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

FRIDAY, MARCH 5, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will be in order, please.

The hearings today are on a number of concurrent resolutions pending before the committee expressing the sense of Congress that the Public Health Service be required to continue to operate a system of hospitals to provide medical care for beneficiaries who have a statutory right to receive such care under the Public Health Service Act.

For a number of years now there have been periodic studies of the Public Health Service hospitals design according to stated purposes of the studies to determine how adequate is the system of medical care for beneficiaries of the service with a view to improving that care.

For a number of years the level of expenditures proposed by the executive branch for improvement and modernization of existing plants and facilities have varied from minuscule to nonexistent, so the studies usually cite potential large costs required to modernize the system.

Last year the Department of Health, Education, and Welfare started another study, this time with a different approach from the usual one. This year's budget assumes the closing of all Public Health Service hospitals, and a study is now underway from the point of view of determining whether or not this decision should be reversed in the case of any specific hospital or clinic.

Apparently, it was intended that the Congress not learn of this decision until the transmittal of the budget in January of this year. But news of the proposal came to the attention of a number of the Members of the House outside regular channels.

As a result, hearings were held last December by the Committee on Merchant Marine and Fisheries and hearings were also held by the committee this year as well.

This committee has legislative jurisdiction over the hospitals of the Public Health Service, and if a proposal is made to close down completely a system of hospitals which have been operating continuously for at least 163 years, it would seem reasonable that this committee be consulted about the proposal in advance. We were not.

The purpose of these hearings today is to explore the question of the proposed closing of all Public Health Service hospitals and clinics, as well as a number of other questions related thereto, such as the future role and the function of the Commission Corps of the Public Health Service.

At this point in the record there will be inserted the text of the concurrent resolutions and agency reports thereon.

(The concurrent resolutions and departmental report referred to follow:)

[H. Con. Res. 98, 92d Cong., 1st sess., introduced by Mr. Long of Maryland (for himself, Mr. Boggs, Mr. Hébert, Mr. Garmatz, Mr. Mitchell, Mr. Sarbanes, Mr. Don H. Clausen, Mr. Murphy of New York, Mr. Anderson of California, Mr. O'Neill, Mr. Addabbo, Mr. Kuykendall, Mr. Pelly, Mr. Badillo, Mr. Jones of North Carolina, Mrs. Hicks of Massachusetts, Mr. Burton, Mr. Pucinski, Mr. Rarick, Mr. Mikva, Mr. Brooks, Mr. Gibbons, Mr. Begich, Mr. Helstoski, and Mr. Harrington) on January 29, 1971;

H. Con. Res. 99, 92d Cong., 1st sess., introduced by Mr. Long of Maryland (for himself, Mr. Van Deerlin, Mr. Eckhardt, and Mr. Hastings) on January 29, 1971;

H. Con. Res. 108, 92d Cong., 1st sess., introduced by Mr. Long of Maryland (for himself, Mr. Burke of Massachusetts, Mr. McCormack, Mr. Biaggi, Mr. Tiernan, Mr. Edwards of Louisiana, Mr. Pepper, Mr. Caffery, Mr. Clay, Mr. Rosenthal, Mr. Dellums, Mr. Thompson of Georgia, Mr. Ryan, Mr. Podell, Mrs. Mink, Mr. Moss, Mr. Donohue, Mr. Halpern, Mr. Adams, Mr. Meeds, Mr. Hicks of Washington, and Mr. Whitehurst) on February 2, 1971;

H. Con. Res. 128, 92d Cong., 1st sess., introduced by Mr. Long of Maryland (for himself, Mr. Hagan, Mr. James V. Stanton, Mr. Byron, Mr. Fulton of Pennsylvania, Mr. Pickle, and Mr. Daniel of Virginia) on February 4, 1971; and

H. Con. Res. 189, 92d Cong., 1st sess., introduced by Mr. Gude on March 2, 1971, are identical as follows:]

CONCURRENT RESOLUTION

Whereas the President declared in his state of the Union message that the improvement of national health care is one of his six great goals; and

Whereas the President vowed to provide more medical services in areas that do not have adequate medical facilities; and

Whereas the Public Health Service was created by an Act of Congress in 1798, and the Congress broadened its responsibilities in 1956, in 1966, and in 1970 to provide comprehensive health care for merchant seamen, Coast Guardsmen, and military personnel and their families, and preventive medical care for urban and rural areas with inadequate medical facilities; and

Whereas the Public Health Service facilities provide medical services to more than one-half million people annually who could not obtain these services in the overcrowded private hospitals or on a first priority basis in the Veterans' Administration hospitals; and

Whereas certain Public Health Service facilities, such as the Baltimore Public Health Service Hospital, require only minor alterations to carry out their responsibilities; and

Whereas, despite the President's commitment to improve national health care, the President's fiscal 1972 health budget proposes a reduction in patient funds that is discouraging employees and prospective employees of the Public Health Service; and

Whereas, despite the expansion of Public Health Service duties in the 1970 Emergency Health Personnel Act, the Secretary of Health, Education, and Welfare is considering closing the Public Health Service hospitals and clinics notwithstanding the fact that the Comptroller General ruled in 1965 that the Secretary does not have the authority to close all Public Health Service hospitals without Congressional approval; and

Whereas, despite congressional creation of the Public Health Service, the Congress has not been consulted on ways to fulfill the responsibility of the Public Health Service to care for its patients without using Public Health Service facilities: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of Congress that the Public Health Service hospitals and outpatient clinics remain open. The importance of health care delivery in urban areas is so great that it would seem appropriate for the Secretary to fund and staff these facilities at a sufficient level to allow them to perform their multipic responsibilities during the remainder of fiscal 1971 and all of fiscal 1972. During that interval, the Secretary and the Congress should explore the resources, capabilities, and position of these facilities in the community to determine which of these facilities should continue to be operated by the Public Health Service and which, if any, should be closed.

It is the further sense of Congress that this system of eight hospitals and thirty clinics, although small, should be considered an integral part of the national health care delivery system.

[H. Con. Res. 119, 92d Cong., 1st sess., introduced by Mr. Macdonald of Massachusetts on February 3, 1971]

CONCURRENT RESOLUTION

Whereas the President declared in his state of the Union message that the improvement of national health care is one of his six great goals; and

Whereas the President promised to provide more medical services in areas that do not have adequate medical facilities; and

Whereas the Public Health Service was created by an Act of Congress in 1798, and the Congress broadened its responsibilities in 1956, 1966, and in 1970 to provide comprehensive health care for merchant seamen, coast guardsmen, military personnel and their families, and preventive medical care for urban and rural areas with inadequate medical facilities; and

Whereas the Public Health Service facilities provide medical services to more than one-half million people annually who could not obtain these services in the overcrowded private hospitals or in the Veterans' Administration hospitals; and

Whereas by decision dated June 7, 1965, the Comptroller General ruled that the Secretary does not have the authority to close all Public Health Service hospitals and generally refer beneficiaries to facilities outside the Service; and

Whereas despite assurances by the Secretary of Health, Education, and Welfare that no final decision has yet been made as to whether the hospitals and clinics should be closed, the budget submitted by the President envisions the use of Service agreements with private and Federal sources for the care of Public Health Service beneficiaries and the conversion of the existing facilities to community use, and contains little or no funds for the payment of salaries of officers and employees of existing Public Health Service hospitals and clinics: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of the Congress that the Public Health Service hospitals and outpatient clinics not only remain open and funds be made available for the continued operation of such hospitals and clinics, but that additional funds be made available for the modernizing, upgrading, and expanding of all existing facilities in order properly to carry out the responsibilities of the Public Health Service to provide the best medical care and treatment to beneficiaries entitled thereto under the law.

[H. Con. Res. 149, 92d Cong., 1st sess., introduced by Mr. Garmatz (for himself, Mr. Byron, Mr. Sarbanes, Mr. Mitchell, Mr. Dickinson, Mr. Nichols, Mr. Begich, Mr. Steele, Mrs. Grasso, Mr. Gubser, Mr. Haley, Mr. Metcalfe, Mr. Mikva, Mr. Murphy of Illinois, Mr. Kluczynski, Mr. Collins of Illinois, Mr. Annunzio, Mr. Rostenkowski, Mr. Pucinski, Mr. Gray, Mr. Price of Illinois, Mr. Bray, Mr. Winn, Mr. Giaimo, and Mr. Madden) on February 10, 1971;

H. Con. Res. 150, 92d Cong., 1st sess., introduced by Mr. Boggs (for himself, Mr. Hébert, Mr. Caffery, Mr. Waggonner, Mr. Rarick, Mr. Edwards of Louisiana, Mr. Long of Louisiana, Mr. Stubblefield, Mr. Mazzoli, Mr. Perkins, Mr. Steed, Mrs. Green of Oregon, Mr. Nix, Mr. Byrne of Pennsylvania, Mr. Barrett, Mr. Eilberg, Mr. Rooney of Pennsylvania, Mr. Dent, Mr. Vigorito, Mr. Clark, Mr. Morgan, Mr. Kyros, Mr. Hathaway, Mr. Bennett, and Mr. McMillan) on February 10, 1971;

H. Con. Res. 151, 92d Cong., 1st sess., introduced by Mr. O'Neill (for himself, Mr. Drinan, Mr. Donohue, Mr. Harrington, Mr. Macdonald of Massachusetts, Mrs. Hicks of Massachusetts, Mr. Burke of Massachusetts, Mr. Keith, Mr. Sandman, Mr. Roe, Mr. Gallagher, Mr. Davis of Georgia, Mr. Dulski, Mr. St Germain, Mr. Tiernan, Mrs. Sullivan, Mr. Randall, Mr. Hungate, and Mr. Minish) on February 10, 1971;

H. Con. Res. 152, 92d Cong., 1st sess., introduced by Mr. Downing (for himself, Mr. Whitehurst, Mr. Abbitt, Mr. Daniel of Virginia, Mr. Robinson of Virginia, Mr. Evins of Tennessee, Mr. Fulton of Tennessee, Mr. Blanton, Mr. Dorn, Mr. Mann, Mr. Jones of North Carolina, Mr. Fountain, Mr. Henderson, Mr. Lennon, Mr. Galifianakis, Mr. Edwards of Alabama, Mr. Jones of Alabama, Mr. Udall, Mr. Sikes, Mr. Gibbons, Mr. Rogers, Mr. Pepper, Mr. Fascell, Mr. Hagan, and Mr. Gettys) on February 10, 1971;

H. Con. Res. 153, 92d Cong., 1st sess., introduced by Mr. Murphy of New York (for himself, Mr. Celler, Mr. Pike, Mr. Wolff, Mr. Halpern, Mr. Addabbo, Mr. Rosenthal, Mr. Delaney, Mr. Brasco, Mrs. Chisholm, Mr. Podell, Mr. Carey of New York, Mr. Rangel, Mr. Ryan, Mr. Badillo, Mr. Bingham, Mr. Biaggi, Mr. Stratton, Mr. Hanley, Mr. Howard, Mr. Thompson of New Jersey, Mr. Helstoski, Mr. Rodino, Mr. Daniels of New Jersey, and Mr. Scheuer) on February 10, 1971;

H. Con. Res. 154, 92d Cong., 1st sess., introduced by Mr. Brooks (for himself, Mr. Patman, Mr. Cabell, Mr. Teague of Texas, Mr. Eckhardt, Mr. Wright, Mr. Purcell, Mr. Young of Texas, Mr. de la Garza, Mr. White, Mr. Burleson of Texas, Mr. Gonzalez, Mr. Casey of Texas, Mr. Kazen, Mr. Broyhill of Virginia, Mr. Biester, Mr. Moorhead, Mr. Gaydos, Mr. Preyer of North Carolina, Mr. Broomfield, and Mr. Roberts) on February 10, 1971;

H. Con. Res. 155, 92d Cong., 1st sess., introduced by Mr. Pelly (for himself, Mrs. Hansen of Washington, Mr. Hicks of Washington, Mr. Adams, Mr. Wyatt, Mr. James V. Stanton, Mr. Stokes, Mr. Vanik, Mr. Diggs, Mr. Nedzi, Mr. William D. Ford, Mr. Dingell, Mrs. Griffiths, Mr. McDonald of Michigan, Mr. Karth, Mr. Fraser, Mr. Monagan, and Mr. Fulton of Pennsylvania) on February 10, 1971;

H. Con. Res. 156, 92d Cong., 1st sess., introduced by Mr. Mailliard (for himself, Mr. Don H. Clausen, Mr. Johnson of California, Mr. Moss, Mr. Leggett, Mr. Burton, Mr. Dellums, Mr. Miller of California, Mr. Edwards of California, Mr. Waldie, Mr. McFall, Mr. Anderson of California, Mr. Holifield, Mr. Hawkins, Mr. Corman, Mr. Rees, Mr. Roybal, Mr. Charles H. Wilson, Mr. Van Deerlin, Mrs. Mink, Mr. Culver, Mr. Steiger of Wisconsin, and Mr. Roncalio) on February 10, 1971;

H. Con. Res. 177, 92d Cong., 1st sess., introduced by Mr. Foley (for himself, Mr. Córdova, Mr. Shipley, Mr. Aspin, Mrs. Abzug, Mr. O'Konski, Mr. Hastings, Mr. Green of Pennsylvania, Mr. Forsythe, Mr. Reid of New York, Mrs. Heckler of Massachusetts, Mr. McCormack, and Mr. Flowers) on February 22, 1971; and

H. Con. Res. 191, 92d Cong., 1st sess., introduced by Mr. Matsunaga on March 3, 1971,

are identical as follows.]

CONCURRENT RESOLUTION

Whereas the President declared in his State of the Union message that the improvement of national health care is one of his Six Great Goals; and

Whereas the President promised to provide more medical services in areas that do not have adequate medical facilities; and

Whereas the Public Health Service was created by an Act of Congress in 1798, and the Congress broadened its responsibilities in 1956, 1966, and in 1970 to provide comprehensive health care for merchant seamen, coastguardsmen, military personnel and their families, and preventive medical care for urban and rural areas with inadequate medical facilities; and

Whereas the Public Health Service facilities provide medical services to more than one-half million people annually who could not obtain these services in the overcrowded private hospitals or in the Veterans' Administration hospitals; and

Whereas by decision dated June 7, 1965, the Comptroller General ruled that the Secretary does not have the authority to close all Public Health Service hospitals and generally refer beneficiaries to facilities outside the service; and

Whereas by virtue of hearings held by the House Merchant Marine and Fisheries Committee there is convincing evidence of record to support the continuing and expanding need for the existing facilities of the Public Health Service; and

Whereas despite assurances by the Secretary of Health, Education, and Welfare that no final decision has yet been made as to whether the hospitals and clinics should be closed, the budget submitted by the President envisions the use of service agreements with private and Federal sources for the care of Public Health Service beneficiaries and the conversion of the existing facilities to community use, and contains little or no funds for the payment of salaries of officers and employees of existing Public Health Service hospitals and clinics: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of the Congress that the Public Health Service hospitals and outpatient clinics not only remain open and funds be made available for the continued operation of such hospitals and clinics, but that additional funds be made available for the modernizing, upgrading, and expanding of all existing facilities in order properly to carry out the responsibilities of the Public Health Service to provide the best medical care and treatment to beneficiaries entitled thereto under the law.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., April 8, 1971.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of February 12, 1971, for the views of this Office on H. Con. Res. 98.

H. Con. Res. 98 would express the sense of Congress that Public Health Service hospitals and outpatient clinics remain open for the remainder of fiscal year 1971 and all of fiscal year 1972. The resolution would also provide that:

"During that interval, the Secretary and the Congress should explore the resources, capabilities, and position of these facilities in the community to determine which of these facilities should continue to be operated by the Public Health Service and which, if any, should be closed.

"It is the further sense of Congress that this system of eight hospitals and thirty clinics, although small, should be considered an integral part of the national health care delivery system."

In testimony before the Health Subcommittee, officials of the Department of Health, Education, and Welfare outlined the Administration's plans for the Public Health Service (PHS) hospital system. They indicated that the Department is exploring the feasibility of converting the facilities to local control and use subject to assuring that (1) PHS beneficiaries continue to receive "care equal or superior to that now being provided" and (2) hospital beds needed for medical services will not be eliminated.

The Department also reaffirmed a commitment made by the Secretary of Health, Education, and Welfare before the House Appropriations Committee that the Department is "fully prepared to propose an amendment to the budget now before Congress to cover the costs necessary to assure the provision of equality care to PHS beneficiaries, if this cannot be done within the amounts already requested."

In view of the Administration's position, we believe action on H. Con. Res. 98 is not necessary.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

Mr. ROGERS. Our first witness this morning is the distinguished chairman of the Committee on the Judiciary, the Honorable Emanuel Celler of New York. Welcome Mr. Chairman. Please proceed as you see fit, sir.

STATEMENT OF HON. EMANUEL CELLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. CELLER. Mr. Chairman, I make this statement to your subcommittee on behalf of the New York Congressional Delegation in connec-

tion with your consideration of those concurrent resolutions on the continuation of the Public Health Service Hospitals and out-patient clinics.

I am confident that witnesses appearing before you will spell out in detail the consequences to communities throughout the Nation were plans to dismantle PHS hospitals and clinics acted upon. Directly, services to merchant seamen and Federal employees would be cut off. Then too, services made available to the general public would cease. These facilities also serve collateral, yet vitally important, programs.

Illustratively and with regard to the Staten Island Hospital in New York, there are more than 250 college students at Staten Island Community College dependent upon the educational programs and facilities of the hospital on Staten Island for their education in vital and undermanned health fields. Programs undertaken there in nursing, medical technology, and related fields are rapidly growing.

One of the major thrusts in helping to alleviate an acute shortage of college trained health workers—in which field it is estimated by one source that the supply will fall short by about 25 percent of the 1.7 million people needed by 1980—is the combined effort of SICC and the USPHS Hospital to offer jointly college-hospital programs for education and training in the allied health field.

Since its inception in 1965, 200 SICC nursing students have used the USPHS Hospital for clinical training. Currently, 130 SICC nursing students are receiving clinical experience at the hospital. Also, since its inception in 1965, over 50 SICC students in medical laboratory technology have received their clinical training at the hospital and, at present, 27 students are doing part of their academic work there.

The hospital has also made its facilities available for the training of 20 disadvantaged women as medical transcribers and another 20 will be so trained commencing February 1.

Jointly planned programs between the college and the hospital include the Orthopedic Assistant program which will, at the outset in September 1971, recruit 30 returning veterans. Still another program to be initiated in September 1971 will be the Community Service Assistant which will be directed at recruiting disadvantaged members of the community for training and education as mental health technicians, social work assistants, welfare case aids, et cetera. Plans are also being developed for initiation of programs for the dental assistant, dental hygienist, and X-ray technician.

Given the limited hospital facilities on Staten Island (3 voluntary, 1 proprietary, and 1 municipal geriatric), the hospital component of such training programs would be limited and insufficient without the use of the Public Health Service Hospital as a training facility. The hospital not only serves the needs of the Federal Government in providing a public health facility for the port of New York; it also contribntes heavily to the health needs of the Staten Island community, significant portions of the Borough of Brooklyn, and New York City in general.

In view of the lack elsewhere of clinical facilities and clinical personnel to train students, should this hospital be phased out, the SICC faces the grave prospect of being compelled to phase out 90 percent of its paramedical programs. This would be an intolerable loss to New York City.

Beyond expressing our concern about the consequences of cutting back needed programs should the hospital be shut, we join in questioning the legality of unilateral action by the executive in planning to erode the Public Health Service system by chipping away at its integral parts.

For these reasons, it is respectfully urged that your subcommittee act favorably on the resolutions expressing the sense of Congress that the PHS hospitals and out-patient clinics remain open and that they be improved, as called for therein.

Mr. ROGERS. Thank you, Mr. Celler, for your views on this important matter before us today.

Mr. CELLER. Thank you, Mr. Chairman, for holding these hearings.

Mr. ROGERS. Next, we shall hear from our colleague from the State of Washington, the Honorable Thomas M. Pelly. Please proceed, sir.

STATEMENT OF HON. THOMAS M. PELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. PELLY. Mr. Chairman, I appreciate this opportunity to express my views regarding the proposal to close Public Health Service hospitals. This is a matter of great concern in the Seattle, Wash., area, part of which I represent, where a very fine PHS hospital is located. The Seattle facility is important to many persons throughout the entire Pacific Northwest, and it runs at a high occupancy rate.

A couple of months ago, Health, Education, and Welfare Secretary Elliott Richardson testified before the House Committee on Merchant Marine and Fisheries, of which I am a member, and he said the Department's plan was to contract out the medical needs of those entitled to care at the PHS hospital.

Mr. Chairman, this is no answer to the Seattle situation. The PHS average daily patient load in Seattle is 198, at a cost of $52.55 each. This is, as I said, a high occupancy rate, and yet HEW is talking of closing this facility and transferring these patients to the VA hospital where the daily cost is nearly $3 more per patient each day. In addition, the VA hospital has a waiting list for admission, and it very simply could not stand to take on the additional patient load.

What is more, Mr. Chairman, HEW offers an alternative of contracting out to other hospitals for the patient care. The Seattle area hospitals are filled to capacity already, and this plan is neither practical nor economical.

Naturally, I join anyone in Congress who wants to cut Government costs, and I would support a continuing study of such costs to make certain that expenses are being kept down, but I cannot support this blanket plan of closing PHS hospitals.

President Nixon has said we are facing a "health crisis" in America, and I will continue to work for the perpetuation, modernization, and utilization of public service hospitals rather than for a program of destroying the present system.

What is additionally vital in the Seattle region, is that the University of Washington's School of Medicine is heavily dependent upon the facilities of the PHS hospital in their training of our Nation's future doctors. The PHS facility is considered an essential part of this process.

Cancer research also is being conducted at the PHS hospital by the University of Washington, and, as a result, one of the Nation's finest facilities exists there.

I won't belabor these issues to the committee, Mr. Chairman, but I want the record to show that I am adamantly opposed to closing Public Health Service hospitals at this time, and I shall work to continue them at the funding level necessary to permit them to continue the excellent care that has become their hallmark.

Mr. ROGERS. Thank you, Mr. Pelly, the committee appreciates your concern in this matter.

Mr. PELLY. Thank you, Mr. Chairman, for affording me the opportunity of presenting my views.

Mr. ROGERS. Our next witness is the Honorable Kika de la Garza of Texas. Welcome, Mr. de la Garza. Come forward, sir, and present your statement.

STATEMENT OF HON. KIKA DE LA GARZA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. DE LA GARZA. Mr. Chairman, I wish to add my voice to those favoring passage of this resolution in opposition to the announced plan of the Department of Health, Education, and Welfare to close Public Health Service hospitals.

Mariners in my area, where the fishing industry is of great importance, are served by such a facility, one at Galveston, Tex. This hospital served almost 45,000 patients last year, including many from the 15th Congressional District. Shutting down this facility would work a real hardship on the people who make use of it.

I believe strongly that this and other Public Health Service hospitals should be kept in operation, and I urge favorable consideration of the resolution expressing the sense of Congress to that effect.

Mr. ROGERS. Thank you, sir, for your concise statement.

Mr. DE LA GARZA. Thank you, Mr. Chairman.

Mr. ROGERS. Next we shall hear from the Honorable Shirley Chisholm of New York. Welcome to the committee, Mrs. Chisholm, we are pleased to hear from you.

STATEMENT OF HON. SHIRLEY CHISHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mrs. CHISHOLM. Members of this committee have heard voluminous testimony in favor of keeping the remaining hospitals and 26 clinics of the Public Health Service system open. Congress has reaffirmed its support for this PHS system repeatedly; it remains to be seen whether this administration will take great cognizance of congressional intent than other administrations have done in the past.

The PHS system dates from 1798 when a network of hospitals was established at various ports around the country to serve the health needs of our merchant seamen. In 1913, this system of marine hospitals was renamed the Public Health Service and the variety of people it serves was expanded to include seamen, active and retired personnel of the Army, Navy, Air Force, Marines, Coast Guard, PHS, Environmental Science Services Administration and their dependents. All receive free medical care through this system.

As the number of seamen in our merchant fleet declined, so did the number of PHS system hospitals and the interest of each subsequent administration. To borrow a phrase, our PHS system medical facilities have been suffering from benign neglect for the last 25 years.

No one argues that the health needs of our merchant seamen force have declined as our fleet become more mechanized. Seamen now comprise only 52 percent of the patients served. Nor would any Member of this Congress disagree with criticism of the low occupancy rate of the PHS system hospitals. Secretary Richardson has indicated that the PHS system's overall average occupancy rate is below 70 percent with the highest rate of 78 percent at Galveston and the lowest at 65 percent in Seattle while the optimum occupancy rate for a hospital is 85 percent to 90 percent.

The problem is that this fact does not reflect the dire need for health care facilities in the country as a whole. This administration and others before it seem determine to shut down the entire system. To Congress, this seems a little like throwing the baby out with the bath water.

What is needed is the reorganization and redirection of the focus of the PHS system to new consumer groups; to the expansion of programs for the poor; the launching of new health offensives on the drug and veneral disease epidemics which are sweeping the country today, and finally to provide a showcase for new initiatives in the delivery of health care.

This was the intent of Congress in 1965 when HEW was ordered to expand and modernize the PHS system. This was the intent of Congress when it authorized the partnership for health legislation and when it passed the Emergency Health Personnel Act of 1970. The intent of Congress has been clear every step of the way. HEW has simply refused to recognize the mandate of Congress. They have refused to spend the moneys authorized for this purpose and have refused to expand and refocus the PHS system.

As for the criticism that the eight PHS hospitals are outmoded, there are some 7,300 hospitals in the United States and according to Dr. Charles Flagle of Johns Hopkins School of Public Health, about 80 percent of these are as old or older.

The idea that veterans hospitals and local community hospitals will be able to absorb the 535,000 people now being served by the PHS is absurd. Both public and private hospitals are already seriously overcrowded and veterans hospitals are now hardpressed by veterans returning from Indo-China.

Equally ridiculous is the idea that communities will somehow be able to find the resources to take over the PHS hospitals and clinics. Most hospitals and medical schools are already in serious financial difficulties because of the cutbacks in medical research moneys which for years have been used to subsidize our health system. New York City is bankrupt. It is cutting back its public services, not expanding them. Our cities have dried up all sources for new tax revenues.

Even if existing facilities could absorb the increased patient load, it would not be a saving to the Federal Government. The average cost per day in a PHS facility is $65 to $70 and this includes everything from doctors' salaries and lab tests to X-rays and drugs. The daily charge in a typical "civilian" hospital is $90 to $115 for room and board alone. These additional per patient costs would ultimately be passed

along to the American taxpayers. It amounts to higher costs for less service.

Let us instead invest the $125 to $175 million necessary to finance the modernization of the PHS hospitals and clinics.

As for the old canard that the PHS hospitals cannot attract high quality doctors, they could if everyone in the health field didn't expect HEW to try to close the facility every year. Many of the doctors in the 5,500 PHS Officer Corps are there because of the draft. They are young and they are imbued with a desire to really have an impact on health care delivery in our country.

They are aware and are ashamed of the state of health care in our country today. We rank 13th among industrialized nations in infant mortality, 11th in life expectancy for women and 18th in life expectancy for men.

Currently, only 5 percent of all present recruits to PHS stay after their military obligation is over. This would not be the case if HEW would undertake the task Congress has requested them to, that is, to revitalize the Public Health Service and make it the leader and developer of new health care initiatives.

Look at what has been happening to our law school graduates. Given the opportunity to work in legal services, many of them preferred this role overwhelmingly to the staid, safe, offices of a corporate law firm. Young medical school graduates are no different, or a lot of old health care personnel for that matter.

Mr. ROGERS. Thank you, Mrs. Chisholm, for taking time from your busy schedule to share your views with us this morning.

Mrs. CHISHOLM. Thank you, Mr. Chairman, it has been my pleasure.

Mr. ROGERS. The Honorable Goodloe E. Byron of Maryland, our colleague from the full committee is our last congressional witness this morning. Welcome, Mr. Byron. Please proceed as you see fit.

STATEMENT OF HON. GOODLOE E. BYRON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. BYRON. Mr. Chairman, I am presenting this statement in support of the House Concurrent Resolution before this subcommittee. The decade of the 1970's began with the public and its representatives being aware of the magnitude of the public health crisis facing the Nation. The correspondence I receive across my desk each day is indicative of the extent of that crisis and the public awareness of it. The proposal to cut back on the services provided by the Public Health Service Hospitals and out-patient clinics comes at a time when health services are desperately needed.

The Morning Herald of Hagerstown, Md., published an article on January 6, 1971, indicating how vital the Public Health Service Hospital in Baltimore is to one of my constituents. A young man, the victim of Hodgkin's disease, has been receiving treatment at the hospital in Baltimore for over 4 months. These treatments have been highly successful, and the young man credits the cancer research facilities at the Public Health Service Hospital with keeping him alive. I have received letters from all over the State of Maryland from medical doctors and ex-patients of the hospital asking that it remain open

and stating their dependence on the hospital for excellent medical treatment.

Many hospitals in Maryland are dependent on the Public Health Service Hospital in Baltimore for training on advanced equipment and in advanced techniques. I urge the subcommittee, Mr. Chairman, to consider the needs of the American people and look favorably on the legislation before you.

Mr. ROGER. Thank you, Mr. Byron.

Mr. BYRON. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness at these hearings will be Dr. Roger O. Egeberg, Assistant Secretary of Health, Education, and Welfare, accompanied by Dr. Vernon E. Wilson, Administrator, Health Services and Mental Health Administration, and Mr. Bruce Cardwell, who is the Comptroller for the Department of Health, Education, and Welfare.

At this point I would like to place in the record the letter I received from the Secretary stating he cannot attend these hearings but has sent Dr. Egeberg to present the testimony of the Department; and also a letter I received from the Director of the Office of Management and Budget, Mr. Shultz, that he cannot appear since he will defer to the Department and its testimony.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., March 3, 1971.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Welfare, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR MR. ROGERS: This is in reply to your letter of February 25 concerning the hearings scheduled by your Subcommittee on March 5, 1971.

Since I will be unable to attend. I have asked Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, to represent the Department as the witness on the Public Health Service hospitals and other facilities. He will be accompanied by Dr. Vernon E. Wilson, Administrator, Health Services and Mental Health Administration.

Sincerely,

ELLIOT RICHARDSON, *Secretary.*

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., March 2, 1971.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Welfare, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This will acknowledge your request for a spokesman for the Office of Management and Budget to appear before your subcommittee to discuss the operations of the Public Health Service hospitals.

Since this is a matter which is under the direct administration of the Department of Health, Education and Welfare and since that Department is the spokesman for the Administration on this and other matters relating to health, I defer to that Department.

I know that the Department will provide your subcommittee with a full and detailed presentation of its position.

Sincerely,

GEORGE P. SHULTZ, *Director.*

Mr. ROGERS. Dr. Egeberg, we welcome you and your associates. We will be pleased to hear your testimony.

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. VERNON E. WILSON, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND BRUCE CARDWELL, COMPTROLLER, HEW

Dr. EGEBERG. Thank you, sir.

Mr. Chairman and members of the committee, at the request of the committee, we are here today to discuss our plans for the Public Health Service hospitals system. My objective is to be as direct and as specific as possible in telling you what we are trying to do with the hospitals—what has happened thus far and what is likely to happen in the future.

I know that you have all been deluged with statements, rumors, explanations, and much more concerning this subject. You may read in the paper one day that the administration plans to close abruptly all of the hospitals. You may read the next day that the administration has changed its position and it will keep them all open. On the third day, someone may tell you that we plan to close some but keep others open. I can assure you that I hear an equal number of rumors as I go about the country. If we are to put this matter in proper perspective, it is essential that we clear the board of all these claims and counterclaims. We must start with a clean slate. I hope we can all set aside or try to forget all of the confusing and conflicting reports that one hears about the administration's plans for the Public Health Service hospitals. Having asked you to join us in that, I would like to describe to you fully and frankly just what it is that we have under consideration, exactly what it is that we are doing and what we are not doing.

CONCERN ABOUT THE EFFECTIVENESS OF THE PHS HOSPITAL SYSTEM

The first thing you should know is that the Department is deeply concerned over whether the present system of Public Health Service hospitals is the best means of fulfilling our responsibilities to merchant seamen and other Public Health Service beneficiaries. I know that you share this concern.

I would like to spell out for you some of the reasons why we are examining the role of the PHS hospital system:

1. In recent years, there has been a steady decline in the Public Health Service patient load, particularly among our primary beneficiaries such as merchant seamen. There may, from time to time, have been exceptions to this, but this is clearly the overall trend, and indications are that it will continue into the future.

This declining patient load is making it more and more difficult to justify and maintain all of the departments and services of a first class, modern hospital. While the optimum occupancy rate for a hospital is 85 to 90 percent of bed capacity, the current overall average for the PHS hospital system is below 70 percent, with the high being 78 percent at Galveston and the low being 65 percent at Seattle. Thus, not one PHS hospital is operating even close to the optimum utilization rate.

2. As a general proposition, cthe facilities themselves have become outdated. A large modernization program would be required to make them first class, up-to-date facilities. Although this is not the primary element of consideration, the fact that it would cost between $125 and $175 million to finance such a modernization program is reason enough to at least stop and examine other alternatives.

3. Although there may be some who take exception to the contention that there is a serious doctor and health manpower shortage, everybody agrees that our current supply is neither properly distributed nor utilized with maximum efficiency. If one examines the share of this scarce resource that is working for the Federal Government, he must, I believe, conclude that the Federal Government has a special responsibility to make the best possible utilization of each and every doctor at its command.

Thus, when I find underutilization of manpower in the Public Health Service hospital system—a system that is under the direct control of the Department that is supposed to be leading the way to improved health manpower utilization—I must explore alternatives that might lead to a more efficient utilization of this manpower.

WHAT WE ARE DOING NOW

I would like to make it very clear that what we are doing now is exploring alternatives for solving the problems inherent in the present system while fulfilling our responsibility to provide high quality medical care to merchant seamen and other beneficiaries. Our options are still open.

As a framework for developing options to consider, the Secretary has set down two very specific conditions which any proposal to change the PHS hospital system must meet.

1. We must, without exception, continue to provide care to our beneficiaries which is equal or superior to that now being provided.

2. No alternative that would eliminate hospital beds needed for medical services by the local community should be considered.

Given the Secretary's ground rules, we are exploring the following alternatives.

1. Conversion of the facilities to local control and use, with full reliance on contract care arrangements for the provision of services to PHS beneficiaries—with the converted hospitals being the major sources for such contract care.

2. Conversion of the facilities to local control and use, but providing all of the required care for our beneficiaries through contracts with public and private hospitals with little reliance on the converted PHS facilities or VA hospitals.

The theme of community use of the PHS hospitals runs through these alternatives for a very good reason. When the primary beneficiary patient load declines, a greater proportion of the hospital capacity becomes available for other uses. An analysis of our patient load data indicates that, if the hospitals were utilized at an optimum rate, only 40 percent of the available beds would be for primary beneficiaries. If the doors were opened to community patients, these patients would, therefore, make up over half of the patient load. Our site visits made in January under Dr. Wilson confirmed this estimate.

Since, under conditions of optimum utilization, over half of the patient load would be community patients, it is logical for us to seriously consider community operation of the hospitals themselves.

We will take the two alternatives mentioned above to the communities for indepth discussion and review. I believe it is important at this point to make clear that the visits to each of the eight cities that were conducted by staff of the Health Services and Mental Health Administration in January did not cover these two alternatives. They were intended to assess the general situation in each of the eight cities—to identify sources of community interest and to examine firsthand the exact situation concerning patient load and staffing. I am afraid that the impression has been given that these visits were for the purpose of making choices and decisions. Let me emphasize that that was never our intention.

We are now at a stage where we believe we can examine in depth, with each of the local communities, their interest in an arrangement that would place the facility under local control. We are now prepared to negotiate with each of the communities. The following would be included in such discussions:

1. PHS beneficiaries currently eligible and receiving care in the facilities must continue to receive the same or improved services, either at the converted facilities or elsewhere in the area.

2. Special departments for services currently in operation in each of the facilities should continue. This would include coronary care units, kidney dialysis units, and the like.

3. HEW or other federally sponsored research and training activities operated at the facility would be continued to the extent that this might be mutually beneficial to the community and the Government.

4. Any public or private group wishing to take over the facility must show evidence of having the professional and financial resources to operate the facilities in a stable and efficient manner.

5. The local group would also be asked to link with the area-wide planning agency in its region to assure maximum integration of the facility and its services with other health delivery resources in the community.

6. We would be prepared to commit at least a portion of the Commissioned Corps personnel currently assigned to the hospitals for some reasonable transition period. This is authorized under the Emergency Health Personnel Act of 1970. Thus, the local community would be assured of a basic cadre of experienced professional personnel.

7. The local community would, of course, be able to collect and retain third-party income related to services provided to non-PHS beneficiaries.

It is still much too early to predict whether such negotiations will produce viable arrangements that would be acceptable to both the community and the Government, but we believe that they stand a good chance of being successful. Our hopes are high because the conversion of a PHS hospital offers each community a quick way of augmenting its medical care resources.

Frankly, the cost implications of the alternatives I am presenting you are still somewhat unclear. In this context, I would like to underscore a statement made by the Secretary during his discussion of the

Public Health Service hospitals before the House Committee on Appropriations on February 17. He said, and I quote:

I want to emphasize that should our efforts be unsuccessful we will request whatever additional appropriations are required to provide medical care for our beneficiaries.

In other words, we are fully prepared to propose an amendment to the budget now before the Congress to cover the costs necessary to assure the provision of quality care to the PHS beneficiaries, if this cannot be done within the amounts already requested.

We ask this committee to give us the opportunity to pursue the alternatives I described earlier, with the understanding that what we are trying to do is improve not only the care for PHS beneficiaries but improve the utilization of health manpower and facilities in all of the communities where the PHS hospitals now exist.

This concludes my prepared statement. I will be happy to answer any questions you may have.

Mr. ROGERS. Thank you, Dr. Egeberg, for your statement.

Mr. Satterfield?

Mr. SATTERFIELD. Dr. Egeberg, in reading your statement, it is pretty obvious you consider the options still open, and it is somewhat questionable in my mind to what extent you have discussed this matter and the alternatives involved with the localities.

Has there been any such discussion?

Dr. EGEBERG. A great deal. I would like to defer you to Dr. Wilson for that because he personally took charge of seeing to it that all the localities, all the Congressmen concerned were involved.

Mr. SATTERFIELD. When you say all the Congressmen involved, who do you mean?

Dr. EGEBERG. The Congressmen in whose districts the hospitals were.

Mr. SATTERFIELD. Not this committee.

Dr. WILSON. I believe there was a notice to the staff of this committee at the time we went out for the original visits. At that time we were simply in the position of saying we were doing a study. We did, however, notify the staff of the various committees in advance of the time we went out for the study.

Mr. ROGERS. What date was that, if the gentleman will yield?

Dr. EGEBERG. Sometime in the middle of January.

Dr. WILSON. But there was advance notice to each of the involved committees.

The discussions of the alternatives with the localities have so far not been addressed to any specific entity in the community with the thought that we were trying to negotiate or determine if they would like to enter into this kind of agreement themselves, but rather have been addressed to the responsible groups in the community which have heavy health care responsibilities and which have an understanding of the community needs.

We have asked them, "Would this kind of an idea be something that you think would be seriously discussed by individuals in the community?"

Those discussions have been occurring on an individual basis over the past 10 days, I guess, or something like that. We have had such discussion with at least one person in each of the several communities.

The objective of these discussions was simply to find out whether

people who knew the health care system in the community, felt that this alternative was worth further discussion and not to ask them for any commitments.

Mr. SATTERFIELD. Then at this moment you really don't know what possible terms might be worked out in each of these areas?

Dr. WILSON. No. I think we would want to emphasize Dr. Egeberg's statement, that what we wish to do is to pursue this line of discussion in order to discover what the physical and managerial implications are.

Mr. SATTERFIELD. How long do you think this study will take?

Dr. WILSON. It is our estimate that it would take probably from now until roughly in September to have a fully worked out set of discussions that could be brought back and discussed in detail with you.

Mr. SATTERFIELD. Does that include contracts?

Dr. WILSON. No. What we are talking about is having someone who is now ready to say that under these conditions this is roughly what he thinks the cost would be and at that time we would be ready to examine a contractual process. We think it would be about a 6-month period.

Mr. SATTERFIELD. What is the intent and how are we going to continue to operate these facilities pending working out a fixed contract?

Dr. WILSON. I would like to let Mr. Cardwell answer that question. if I may.

Mr. CARDWELL. We would continue in operation the present system with all of its existing services until such time as we could make firm and clear agreements and until such time, hopefully, as we could develop a consensus concerning those agreements.

Mr. SATTERFIELD. I don't construe the 1972 budget as reflecting that.

Mr. CARDWELL. I would agree with you, but I would also underscore the reference that Dr. Egeberg made to the Secretary's two statements.

He made a statement in January at the time the budget was sent to Congress indicating that this was an assumption of the budget and it would not necessarily prevail. Whether or not it prevailed and the extent to which it might be changed would depend on the outcome of our final decision.

Our department, and this is an explicit commitment on the part of the administration, would come forward with whatever additional funding might be required.

Mr. SATTERFIELD. Is it the intention of the administration to handle this entirely before the Appropriations Committee or to also consult with this committee?

Mr. CARDWELL. We do not intend to restrict our congressional discussions of this issue to the Appropriations Committee. I think, as you can well appreciate, there are varying interests in this subject in the Congress. My own opinion is that the interest of the House is extensive and involves both individual Members whose districts are affected and certain committees. Most notably it involves this committee and the Committee on Merchant Marine and Fisheries. The funding is but a part of the problem and perhaps the smallest part.

Mr. SATTERFIELD. I would like to refer you to the concurrent resolution pending before us, No. 98, which I think is typical of the rest before us. There is a statement in one of the "whereas" clauses, that the Comptroller General ruled in 1965 that the Secretary does not have the authority to close all Public Health Service hospitals without congressional approval.

If you are going to contract these hospitals away, I construe it to be the same.

Is there a new interpretation of this power on the part of the Secretary?

Dr. EGEBERG. We have discussed this. Our Legal Division under Mr. Hastings in investigating this further, and I think will have an interpretation or a decision on that. Both people being lawyers, I imagine there will be perhaps a number of decisions.

But we expect to have it clarified within the next week or two for our Department's stance.

Mr. SATTERFIELD. There is one other question I would like to ask. This resolution merely says that it is the sense of Congress that we continue to fund Public Health Service hospitals and continue to operate them through fiscal year 1972, and that in the interim the Secretary and Congress will explore resources, capabilities, and all the things relating to what we are talking about.

Do you take a position this morning against that proposition or do you support it?

Dr. EGEBERG. No, that is the proposition we are really working on, except supposing that by September, October there were clear other solutions for one hospital, let us say.

However, I personally can't see things happening quite that fast. But it is conceivable that one hospital might be ready to go into community hands, associated with a medical school or something like that.

Mr. CARDWELL. Could I comment on that particular point?

I think the basic spirit of the resolution is something to which we could subscribe. The thing that we are not quite certain of at this point is what is the real intent of it.

I think different people are going to read it in different ways. I think some people in the Congress may well read it as a congressional directive forbidding the Executive to take any action at all, and that it means a permanent and continuing operation of the present system, with all of its facilities, in its present form.

To the extent that any part of the Congress or any individual member or any group sees that as its intent, we could not agree with it.

I would suggest to the chairman and to the committee that since the Secretary is not here today, we will do our best to respond as fully to your questions, including this one, as we can, but I would urge the committee to ask him to give you a written comment on your basic question because I think it is a very important question and we should not have a misunderstanding.

Mr. SATTERFIELD. I, for one, would like to have that. I would also like to have the opportunity to talk to the Secretary. I am sorry he is not here this morning.

(The following letter was received for the record:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., March 19, 1971.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. ROGERS: This letter is in response to your request at the recent hearings on the PHS hospital system and in a telephone conversation on March 16 for a statement from me concerning:

1. Whether we plan to seek a budget amendment restoring the budget for the PHS hospital system to the 1971 level of operation; and

2. What the Department's position is with regard to House Concurrent Resolution 98 recommending that the budget for the PHS hospital system be restored pending an exploration of the "resources, capabilities, and position of these facilities in the community to determine which of these facilities should continue to be operated by the Public Health Service and which, if any, should be closed."

We want our position on these matters to be clear to you, your Committee, and to the Congress generally. In order to put the answer to your questions in perspective, let me emphasize what we are committed to do:

First, we propose to negotiate with public and private representatives of the local community to determine whether the facility is needed for that community and, if so, whether a viable arrangement might be made for turning the facility over to the community. In this regard, as I believe HEW representatives pointed out at the hearing, we will take no steps to close out beds or services for which the community has a demonstrated need.

Second, we are committed to explore the potential for providing medical services to Public Health Service beneficiaries through other public or private hospitals or clinics and negotiating agreements wherever possible. These explorations will include negotiations with the Veterans Administration to determine whether they might be able to provide some services on a cross-servicing basis without prejudice to their own beneficiaries.

We will embark on these explorations in the immediate future. As was pointed out at the hearing, we cannot be certain as to how long this process will take, but we estimate that we should be able to complete it by early fall.

Insofar as assurances about the budget are concerned, we stand on our previous statements. Our position is—

If the pursuit of the objectives outlined above indicate that the present budget is deficient, we and the Office of Management and Budget will seek the necessary additional funds from Congress. We do not plan to seek those funds until we are certain as to what the final arrangement concerning care for the beneficiaries will be.

Since there is a chance that this matter may not be settled by July 1, 1971, the start of the next fiscal year, we would propose that the current 1971 spending level for the hospitals be authorized under a Continuing Resolution until such time as final determinations can be made concerning 1972 funding requirements. We are aware that in the event this becomes necessary, some modifications or special language may be required in the Continuing Resolution, depending on the status of appropriation action as of July 1. We will monitor this closely and will keep in touch with the Committees on Appropriations and other interested parties in the Congress.

In summary, we are still not prepared to concede that we cannot achieve our objective. But, in any event, should we find that the budget is deficient, we will definitely take immediate corrective action in the form of a request to the Congress for additional funds.

With regard to House Concurrent Resolution 98 I would like to make the following points:

1. Insofar as it expresses a desire to retain the PHS hospitals as a part of the Nation's health care system, we can give the resolution our full support. We maintain, however, that the hospitals could perform their role more efficiently if they were run by the community rather than by the Federal Government.

2. The resolution states that the hospitals be staffed and funded "at a sufficient level to allow them to perform their multiple responsibilities during the remainder of fiscal 1971 and all of fiscal 1972." The implication is that this should be accomplished with Federal funds and staff. We believe that wherever the communities determine that PHS hospitals are needed, they should continue to be operated at adequate levels, but by some community organization rather than the Federal Government. However, if the community should determine that the facility should be closed or put to an alternative use, we see no reason why we should be restrained from putting these plans into effect before the end of fiscal year 1972. We would seek additional Federal funding only if the current budget proves to be inadequate to implement any agreements which we might reach with the communities.

3. The resolution recommends that the Secretary of Health, Education, and Welfare, and the Congress should review the situation to determine which hospitals should continue to be operated by the Public Health Service and which, if

any, should be closed. We would add that this review should include the possibility of turning the hospitals over to community control.

4. The resolution maintains that Congress was not consulted when we developed our plans to convert these hospitals to community use. On this point, I would reiterate what we have said earlier: Before putting any plan into operation we will consult with not only the Members of your Committee but also the comparable Committee in the Senate and the Appropriations Committees in both Houses. Members of Congress, therefore, will have a full opportunity to make their views known before any of our plans are implemented.

With kindest regards,

Sincerely,

ELLIOT RICHARDSON, *Secretary.*

Mr. ROGERS. I think we will go under the 5-minute rule, letting each member question for 5 minutes and then come back for further questioning.

Also, I see that one of our new members who has joined this committee is here, Congressman William R. Roy, of Kansas. We welcome him to the committee. He is also a doctor and a lawyer.

He not only knows the medical field but he can ask a lot of legal questions, too. So we welcome him and know he will make a great contribution.

Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

I noted, Dr. Egeberg, on page 6 you skipped over the language "Those visits were simply the first step in our review of the whole program."

Have you stricken that from your testimony?

Dr. EGEBERG. I will read it into the record.

Mr. NELSEN. It reads: "Those visits were simply the first step in our review of the whole problem."

Then you went on that they were intended to assess the general situation. I wanted to know if you had eliminated that.

Dr. EGEBERG. No. That is in the record. I intended to read it.

Mr. ROGERS. I think we should make it clear for the record that this procedure applies not only to the eight hospitals, but it also applies to all of the clinics.

Dr. EGEBERG. Yes.

Mr. ROGERS. How many clinics are there?

Dr. EGEBERG. About 30.

Mr. ROGERS. So it is a proposal to close them as well or take the same action that you would on the hospital?

Dr. EGEBERG. Yes, sir.

Mr. ROGERS. Thank you.

Mr. NELSEN. I am not familiar with the operation of these hospitals. Has the general public in the past been permitted to use these hospitals, or has it been confined largely to the merchant seamen and others?

Dr. EGEBERG. Merchant seamen and the people who work in the Commission Corps of the Public Health Service. Some of the hospitals have begun to take some outside patients and we have studies going on in some that involve outside patients.

I think perhaps Dr. Wilson can give you more specific information on that.

Dr. WILSON. I think you have covered it. The dependents of the Coast Guard and the dependents of the Commission Corps can receive care on an "as available" basis.

The merchant seamen receive care as primary beneficiaries.

Then we have the "as available" or "unique resource capability," where, for example, we have a dialysis unit.

Mr. ROGERS. I don't think you have answered him fully. Also, you treat other Federal employees; do you not? The military?

Dr. WILSON. The military, right.

Mr. ROGERS. Military retired personnel.

Dr. WILSON. That is a fairly small number.

Mr. ROGERS. It is a pretty good number in some areas.

Dr. WILSON. Yes.

Mr. CARTER. What about civil servants?

Dr. WILSON. No.

Mr. CARTER. That has been done.

Dr. WILSON. This is the "unique" or "as available" basis.

Mr. CARTER. Well, it is uniquely available. I have seen it. I am sure this has been true in the past. You may have departed from it.

Dr. WILSON. We don't have authority to do this other than the "unique" part.

Mr. CARTER. I know it has happened.

Mr. NELSEN. Mr. Chairman, I will proceed with the point I had in mind.

If the general public has not been given the right of entry to these hospitals, in the event the program you are pursuing became a reality, would it be your intention that not only would it be available to merchant seamen but also to the community where the hospitals are located?

Do I understand this to be your objective?

Dr. WILSON. That is correct.

Mr. CARDWELL. Could I make a point there? I think it is a basic statistic that might be helpful, and I don't want my citation of statistics to imply that we are not concerned about the primary patient load. We are.

But the primary patient load represents about one-tenth of 1 percent of the total population, a little over 2,000 people in this country. An $84 million enterprise is in operation to serve that one-tenth of 1 percent.

On any given day, the primary patient load represents a little over 1,000 people receiving care against that $84 million enterprise.

So any extension of that program to the community, any broadening of its reach, would certainly seem in order.

Mr. NELSEN. There are eight hospitals involved?

Dr. EGEBERG. Yes.

Mr. NELSEN. Is this the total number we have always had or have there been more?

Dr. EGEBERG. There were many more. Twenty-four was the highest.

Mr. NELSEN. What is the use of those others now?

Dr. EGEBERG. Some of those were very antiquated institutions and may even have caved in.

Mr. CARDWELL. There is no precedent or past experience or past incident where we actually converted a hospital to a community use

and made that a condition of our disengagement from the hospital. This would be the first time that that particular item had been considered. Previously, the hospitals always had been declared surplus to the needs of the Federal Government and they may or may not have been picked up.

I will explore this for the record, but I think you will find most of them were actually abandoned fully and entirely as medical facilities.

(The following information was received for the record:)

DISPOSITION OF FORMER PHS FACILITIES

Cleveland, Ohio.—Conveyed to State of Ohio, 1/14/56, for use as a State mental hospital.

Ft. Stanton, New Mexico.—Conveyed to State of New Mexico, 6/15/56, for use as a TB hospital.

Louisville, Kentucky.—Conveyed to City of Louisville pursuant to P.L. 81-304, 9/8/49.

Manhattan Beach, New York.—Conveyed to City of New York, 8/15/63, for use as hospital and nursing home.

Buffalo, New York.—Conveyed to University of Buffalo, S.U.N.Y., 6/20/56, for use as a research facility.

Pittsburgh, Pennsylvania.—Conveyed to City of Pittsburgh, 5/18/56, for use as a public health administration center and clinic.

Chicago, Illinois.—Conveyed to City of Chicago in 1965.

Detroit, Michigan.—Conveyed to State of Michigan in 1969.

Mobile, Alabama.—Conveyed to Alabama District 4 TB Association, 5/23/53, for use as a TB hospital.

Kirkwood, Missouri.—Conveyed to Sisters of St. Joseph, 10/30/53, for use as a general hospital.

Vineyard Haven, Massachusetts.—Sold as surplus to Boston Seaman's Friends Society, Inc.

We have not been able to ascertain the disposition of the PHS facilities listed below as records are usually not maintained beyond a twenty year period:

	Closed
Port Townsend, Wash	February 1, 1933
Stapleton, N.Y	December 18, 1935
St. Louis, Mo	September 16, 1939
Rockaway Beach, N.Y	June 28, 1950
Evansville, Ind	May 23, 1947

Dr. EGEBERG. And their load was absorbed by other Public Health Service hospitals in their general area.

Mr. NELSEN. I note the resolution gives the impression that the hospitals are about to be closed. As I understand your testimony, you are examining the possibility of making expanded utilization of the facility and where there is a need there is no intention to close them, instead, to make them a better and more available and useful hospital. Am I right?

Dr. EGEBERG. Yes, yes. We don't anticipate the closing of any of these but, rather, a transfer to a different system of operation. It might be connected with a medical school, it might be connected with other hospitals in the community, but not closing.

Mr. NELSEN. I see the chairman is getting ready to ring the bell. He took part of my time.

Mr. ROGERS. I have compensated for that.

Mr. NELSEN. OK.

I am sure, Dr. Egeberg, you would have no objections if this committee went out and looked the places over, would you?

Dr. EGEBERG. No. I would join you.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

Dr. Egeberg, I am delighted to see you again before us. You were aware when you came here this morning representing the Secretary that this hearing was on House Concurrent Resolution 98. Yet, a few minutes ago you said, in your usual genial manner, that you could accommodate yourself to this resolution.

However, the other gentleman sitting to your right said he wanted to reserve judgment, and perhaps have the Secretary send us a letter giving us his opinion.

I want to ask you this morning, for the record, how do you feel specifically about House Concurrent Resolution 98?

Dr. EGEBERG. What I said toward the end of my statement was that I could well conceive of one of the hospitals having reached, or maybe two, but I think I said one, reached the stage during fiscal year 1972 when we might be ready to turn it over.

I felt, therefore, we weren't sure about needing the whole year for all of the hospitals.

As Mr. Cardwell brought out, the fact that that might be a precedent I think very wisely enlarged on what I said.

Mr. CARDWELL. Mr. Kyros, if you will permit me to make a comment, it may have been an oversight on our part or we may not have been very smart, but we did not come specifically prepared to comment on that subject.

As I remember the chairman's letter, it indicated that you wanted to discuss the hospitals, the Commissioned Corps and other aspects of the health program that might be related to the hospitals.

I think if we had been a little sharper we would have also realized since this matter was now pending before the committee, that it would also come under discussion.

That is one reason I would like to ask the committee for the opportunity for the Secretary to comment and present the administration's views.

Mr. KYROS. House Concurrent Resolution 98 simply says that because of the importance of maintaining health care in rural areas, the Secretary would maintain these services at the same level, and it does provide, as Dr. Egeberg said, that examination can go on.

You might even decide to close some hospitals. Otherwise, it says the Congress wants you to maintain the services as they are.

Let me point out something else. You are aware, aren't you, sir, that the Comptroller General of the United States has advised Mr. Garmatz, the chairman of the House Merchant Marine Committee, that the Secretary of Health, Education, and Welfare does not have the legal right to close these hospitals?

Isn't that a fact?

Mr. CARDWELL. That is one man's opinion.

Dr. EGEBERG. That is the Comptroller General's opinion. We are evolving our own with our legal department.

Mr. KYROS. Isn't it also a fact that a similar observation was given by a former General Counsel of the Department of Health, Education,

and Welfare, in a letter dated April 17, 1965, in which he said that the Public Health Service Act requires that the hospitals be maintained open as a public law?

Dr. EGEBERG. Mr. Hastings is taking that into consideration, too.

Mr. CARDWELL. As you probably also know, the current General Counsel of the Department, Wilmot Hastings, did provide the Secretary with a commentary on the previous Counsel's position which was rendered some years ago, and I believed rendered concerning a somewhat different alternative.

Mr. KYROS. So there is sharp question in your mind as to whether that is the law. Is that right?

Mr. CARDWELL. That is what I meant by one man's opinion.

Mr. KYROS. I think the Congress ought to clarify it by passing House Concurrent Resolution 98. Don't you agree?

Mr. CARDWELL. Let me answer the first question first and I will try the second question second.

There is at this point, I would suggest, a difference of opinion between two lawyers—between the Comptroller General and our counsel. Neither our counsel nor the Secretary have had the opportunity to fully review Mr. Staats' latest opinion, but we propose to do so. That was the reference that Dr. Egeberg made to a response, which we will furnish to this committee.

On your second point, if I understand Mr. Satterfield correctly, the proposed resolution specifies that the hospitals would be maintained in operation for the full year 1972 as a minimum. I think this is where we might have a sharp difference.

Mr. KYROS. That is not precisely what it says. I says "subject to your examination."

Mr. CARDWELL. I understood him to say that.

Mr. KYROS. He read as far as he wanted and read accurately.

Let me ask you a final question.

As I understand it, Dr. Egeberg, you have made considerable studies already of these out-hospitals and outpatient clinics?

Dr. EGEBERG. Yes; under Dr. Wilson.

Mr. KYROS. In the outpatient clinic in Portland, Maine, tell me what the local caseload is per month, what other hospital would pick up that caseload, and if there are adequate personnel to take care of the people who would be turned away if you closed the Portland clinic?

Dr. EGEBERG. That is a pretty specific question.

Mr. KYROS. I assume you would be ready to answer that eventually for all clinics.

Dr. EGEBERG. We are.

Dr. WILSON. The outpatient visits total for the year of 1970 were 18,000, of which 5,422 were Public Health Service beneficiaries; 13,000 were community individuals.

The budget for that activity was $204,000. We have another facility available. We can get it for the clinics for a matter of record for Portland. We have the figures available for all the hospitals but perhaps not for the clinics here. We will get it for you.

(The following information was received for the record:)

PORTLAND, MAINE OUTPATIENT CLINIC STATISTICS

Workload (fiscal year 1970):	
Outpatient visits, total	18,434
PHS beneficiaries	5,422
Others	13,012
Budget (fiscal year 1971)	$204,885
Outpatient visit cost (fiscal year 1970)	10.00
Facility:	
Location (acres acquired by PHS in 1857)	6.9
Number of buildings	4
Personnel:	
Commissioned officers, total	4
Civil Service, total	10
Total	14

Mr. KYROS. Does your study analyze who, if you did close down a clinic like this, would pick up that outpatient caseload?

Dr. WILSON. I think you are pursuing an issue that we have not pursued at the moment. That is, that the services would be withdrawn.

Mr. KYROS. No. I assumed what the Secretary said, namely, that you are considering alternatives to see that the beneficiaries, primary and otherwise, would be picked up by other medical facilities. Am I wrong?

Dr. WILSON. That is one alternative. The other alternative, however, I think comes under his statement that he is going to see to it that the people for whom we have responsibility continue to receive medical care and we are looking at it only on that basis. That may involve the operation of that clinic under a different kind of auspices with the current personnel remaining until some adjustment can be made.

Mr. KYROS. But you are making these studies and you will eventually have these figures available?

Dr. EGEBERG. Yes, sir. I think there is one point that one might raise there. Sometimes, particularly for the hospitals, people come from quite a way. The hospital may not be in the best location to take care of those people. It might be better to take care of them, also. That is part of the study, also.

Mr. KYROS. Our clinic is in the best place to take care of the people, Doctor, believe me.

Dr. EGEBERG. It is in the best place?

Mr. KYROS. Yes, sir.

Dr. EGEBERG. Then it will be placed there if it gets placed at all.

Mr. KYROS. Thank you.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

To continue the gentleman from Maine's questioning, you said there were 18,000 admissions?

Dr. WILSON. Visits, not admissions.

Mr. CARTER. What was the composition of those? Have you broken those down?

Dr. WILSON. The composition of those outpatient visits were 5,000, primary beneficiaries. The other 13,000, roughly, were either dependents or secondary beneficaries of one kind or another, or patients treated in response to some community need.

Mr. CARTER. In response to some community need? You haven't defined clearly these other 13,000, to me, at least.

Dr. EGEBERG. They would be people who don't have the primary right but whom this clinic is taking care of in trying to become a broader part of the community.

Mr. CARTER. A community service?

Dr. EGEBERG. Community service.

Mr. CARTER. These are not merchant marines?

Dr. EGEBERG. No; they are primary beneficiaries.

Dr. WILSON. In this instance my staff tell me they were mostly military and military dependents.

Mr. CARTER. The institution primarily was established for the merchant marine, was it not?

Dr. EGEBERG. Yes.

Mr. CARTER. What part of the 18,000 visits——

Dr. WILSON. 5,000, approximately. They are PHS beneficiaries, which is primarily merchant marine.

Mr. CARTER. The census of your hospitals throughout the country is approximately 75 percent?

Dr. WILSON. Seventy percent.

Mr. CARTER. That means that 30 percent of your beds are not used at the present time.

Dr. EGEBERG. That is correct.

Mr. CARTER. And you would like to convert them into use by medical schools where possible, is that true?

Dr. WILSON. To whatever would be the community need that the additional beds or bed capacity would be most useful for. I think our intent would be to improve patient service in the area no matter what the arrangement might be.

Mr. CARTER. You would generalize, is that right?

Dr. WILSON. We would assume that if, indeed, the alternative were being pursued that made the hospital available under some sort of community auspices, that the facility would be available to provide additional services in the community after they met the primary need as determined by the community. That would vary from community to community.

Dr. EGEBERG. In Seattle the medical school is definitely interested in this, and the Veterans' Administration and the Public Health Service hospitals at one time were going to go together. The VA got cold feet.

Mr. CARTER. In that case, the hospital would probably be taken over by the medical school.

Dr. EGEBERG. Yes, sir.

Mr. CARTER. And you would think that the census would be greater, then, than 70 percent in that case. There would be more complete utilization.

Dr. EGEBERG. Yes.

Mr. CARTER. You would be saving money, with further utilization by the communities and the medical schools in the area, is that true?

Dr. WILSON. We are not at the moment thinking of closure in that sense. We are thinking of transfer of responsibility for operating with an expansion of availability of services to the community. I don't know in what context you are using the word "closure."

Mr. CARTER. Closure as a Public Health Service hospital. It would lose the name. But the idea is to give better community service, is that not true?

Dr. WILSON. That is correct.

Mr. CARTER. Those are all the questions I have.

Dr. EGEBERG. And as good or better service to the beneficiaries, too.

Mr. CARTER. Yes.

That is all, Mr. Chairman.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

Dr. Egeberg, I think it has been helpful to clear up the claims and counterclaims and start with a clean slate, as you mentioned.

Whenever you try to close anything that is affected with a public interest and which is a nonprofit institution, you run into some very difficult problems because there is no clear-cut standard that you can measure whether it is good to close or not.

In the world of private enterprise, it is simple: If a business doesn't make money, you cut it right off. It is a clean standard.

But in something affected with the public interest, the standard of efficiency alone is not enough. You make the argument for changing the hospitals on the grounds of efficiency: That the occupancy rate is down, the cost of modernizing and the maldistribution of manpower. But you do recognize the other elements you have to consider; namely, the service to the community side, it seems to me.

You suggest that in meeting that part of the argument, in continuing service to the community, you would explore two alternatives. One would be the conversion of the facilities to local control, with the converted hospitals being the major sources of care.

The second alternative is you would convert to local control through contracts with private and public hospitals, with little reliance on the converted facility.

When we hear about the shortage of hospital beds around the country, isn't it almost a foregone conclusion that the first alternative would have to be the one adopted; that the hospital, itself, would be converted as the major source?

Dr. EGEBERG. Yes; unless one of the hospitals was in such a state of repair that it was inefficient to use that hospital. But on the whole the principle that is guiding us is the search for a broader and better utilization of the structures, of the hospitals, and as good as or better care for the beneficiaries. I think your point is well taken.

Mr. CARDWELL. I was going to say, Mr. Preyer, if you will, note both alternatives. They are really very similar. Both alternatives assume conversion to public use.

The second alternative, though, is one that you have to separate from the first because it is possible in negotiations that the local community would not be interested in an arrangement wherein it had to commit the converted facility to the care for our primary beneficiaries.

In that instance we would have to find a companion arrangement to care for our own beneficiaries in some other facility. That is what separates the two alternatives.

Dr. WILSON. May I comment on this in a slightly different way? In talking to this very limited group of people when we asked, are we proposing something that makes sense at all to you, we ran across two of

the communities where their initial impression was that there were unused beds in the community, contrary to most of the national experience where we have really a shortage of beds. Their initial impression was that it might turn out that they had already more beds of a good condition in the community than were in use, and that is one reason for a cautious approach without getting into the decision of do you or don't you.

Mr. PREYER. The second alternative is to allow exceptions to what would be the rule; namely, the converted hospital being the main source of care. This sounds to me that what you are really doing is converting these hospitals by providing broader care, as you say, which means that we aren't really saving any money. We will be spending probably a lot more money on hospitalization if you do that.

I think the question which the local communities will want to know is who is going to be putting up that money. Assuming this is a great idea to convert them and broaden them, who is putting up the funds to do that?

That isn't going to be a very realistic alternative, I am afraid, if local communities must put up the funds.

Dr. EGEBERG. Medicine and medicaid and private fees will certainly add to our paying for our beneficiaries in helping to run those hospitals. This would be a very important part in enabling them to keep them open.

There is one point I would like to bring out. On the Pacific coast the two hospitals that we have are in San Francisco and Seattle. Probably the two ports having the major work are San Pedro and San Diego. So one might take the beneficiaries that come from San Diego or Los Angeles and arrange for them to be cared for at Santee or at one of the institutions in San Diego or Los Angeles.

It was sort of tangential to your question; perhaps not direct.

Mr. CARDWELL. I think Dr. Egeberg's last point is worthy of consideration by this committee. It is very possible, if you look to the future, if this were to prove feasible, that the merchant marines as beneficiaries might even be better served because it could well lead to the very thing he was talking about, their being able to obtain service closer to their home or port of call. That coulud be the long-range effect. We don't know as yet.

Mr. CARTER. Will the distinguished gentleman yield?

Mr. PREYER. Yes, sir.

Mr. CARTER. Prior to this conversion, would you have Public Health Service personnel who could be detailed to other work?

For instance, according to the bill passed in the last Congress, they could be detailed to go into poverty areas and so on, to better utilize them that way.

Dr. EGEBERG. Yes, sir.

Mr. CARTER. Thank you.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman.

First, I would like to make it clear that the Mr. Hastings that Dr. Egeberg referred to is not this Mr. Hastings. I am not trying to write that opinion at all.

Mr. CARDWELL. I think he would like to have you write it, if you would.

Mr. HASTINGS. I don't know if he would or not.

On the question of cost, I think, Mr. Cardwell, you mentioned the figure of $84 million. Is that the total operating cost today of the eight hospitals?

Mr. CARDWELL. Approximately; yes, sir.

Mr. HASTINGS. That is the budget figure, $84 million?

Mr. CARDWELL. Yes, sir.

Mr. HASTINGS. That is the figure that would have to go back into the budget?

Mr. CARDWELL. Yes, sir; approximately.

Mr. HASTINGS. Do you have any figures on the comparative cost to maintain a PHS hospital as compared to the cost per day per patient in a community hospital in the same area?

Dr. WILSON. Yes; for each of them. Do you have a specific one in mind?

Mr. HASTINGS. No.

Dr. WILSON. Our average cost per day is about $64, and the average cost per clinic visit is between $10 and $11. This is 1970.

Mr. HASTINGS. And what kind of a comparison does that have to the community-operated hospital?

Mr. CARDWELL. It is less.

Dr. WILSON. As I think the chairman will recall, we discussed this point one time before, and our problem occurs when you try to compare this figure with the community hospitals due to the fact that our average patient day stay is close to 17 days.

The community hospital patient day stay is somewhere between 6 and 7 days.

What we have at the moment in the Public Health Service hospitals is a combination of what goes on in the community in extended care, nursing home, and acute hospital.

There is one other factor that is quite important when you look at cost. The operations that go on in these hospitals tend to be appendectomies, tonsilectomies, the simple kind of operation, rather than what you are beginning to find in comparable size university hospitals which have become much more specialized in the work they are doing.

Mr. ROGERS. Would the gentleman yield there?

Mr. HASTINGS. Yes.

Mr. ROGERS. You are not telling us that these hospitals are treating people differently from any community hospital. You said university.

Dr. WILSON. Yes.

Mr. ROGERS. The cost you give us for the Public Health Service hospitals include physicians' costs which are not included in the community figure he gave you. That would zoom it up to I don't know how much.

Dr. WILSON. The community figure contains the resident figure and that comes very close in many instances to the professional costs we have.

Mr. ROGERS. That is not what I hear. I hear there is a great difference between including all of the physician costs in your Public Health hospital figure and the community figures that are given.

Dr. EGEBERG. Yes; but there is a difference.

Mr. ROGERS. I understand the difference. It is in the cost.

Dr. EGEBERG. And in the Veterans' Administration, too.

There is this question of how long you keep a patient in.

Mr. ROGERS. I would think it is the judgment of the physician, isn't it?

Dr. EGEBERG. No. There are many, many factors that enter into it that go well beyond the judgment of the physician in the Veterans' Administration hospitals as well as in these hospitals. They have to do with rights and many other things as far as pensions and other things are concerned.

But if you have a patient in 17 days as opposed to an average of 8 or 9 days, that patient is not getting as much service per day because it is being spread over a longer period of time.

I think that is a very important part in this question of cheapness.

Mr. ROGERS. Well, it depends whether he is in a critical bed or not. If he is moved to a nursing capacity or if he is diseased, if it is a critical bed I would think it would be comparable.

Dr. WILSON. May I give one more piece of information to the Congressman that I think will help as we sort this out. Eighty percent of the cost of hospital care is labor cost. Most of the labor cost is not the professional cost. It is a relatively small percentage of the total cost.

Our salary scales for the nonprofessional people are at or above the community level for such salary scales. So there is another way to look at what we are doing. It is the same group of people who are being paid at or above the community level that gives you a chance to look at it in a slightly different way.

We believe, with apologies to the chairman, that if you do a careful analysis of what is actually going on in the hospital and the complexity of that care and match that against the kind of employees you have to hire to do it, we come up with most of the difference in the two costs based on that factor.

Mr. ROGERS. May I just pursue that?

Are you telling me that you have hired, in your hospital, personnel that you shouldn't have?

Dr. WILSON. No. What we are saying is that the cost of the Commission Corps personnel as it is applied to the per diem cost is a relatively small part of the per diem cost.

What I am saying is that the kind of care that is given in a PHS hospital is much less complex than that which you find in comparable community hospitals.

Mr. ROGERS. That may be true when you compare the cost there. You may say the physician's services don't cost much per diem in your Public Health hospitals. I think that is true.

But then when you get physician's care outside, they are considerable. Wouldn't you agree?

Dr. WILSON. Not in nursing homes.

Mr. ROGERS. I didn't say nursing homes. I said hospitals, comparable care.

Dr. WILSON. Mr. Chairman, what I am saying is, there is a substantial part of this care which is comparable to nursing home and extended care, and that care is not relevant to the problem that you are talking about, and it is included in our per diem rates. That is why it is a complex problem.

I am not trying to have a "did" or "didn't" argument with you. I

am simply saying as you go through it, it is a different kind of an activity because that condition is imposed upon us. We have no nursing homes or extended care homes to use and, therefore, these hospitals do all three.

Mr. ROGERS. Do you know what percentage that is?

Dr. WILSON. You can approximate it, of course, by the days of care, the days of stay.

Mr. ROGERS. I am not sure that is exactly true. You would say just because a man is in the hospital 9 days he is having nursing home care?

Dr. WILSON. Without, I think, pretending to be an expert on what takes a little bit more time, I can give you, I think, anecdotally, some insight into the problems.

Mr. ROGERS. Let me just say this, and I won't pursue it: If you will, furnish for the record the figures, not some theoretical projection but some figures, we would like to have them.

Dr. WILSON. Yes; we can do that.

(The following information was received for the record:)

ESTIMATED DISTRIBUTION OF WORKLOAD BY ACUTE VS LONG-TERM PATIENT CARE DAYS

From an analysis of patient care days in PHS hospitals in FY 69 and FY 70, it is estimated that 72% of the workload is typical of cases in short-term acute general hospitals, the remaining 28% being accounted for by long-term care patients.

Dr. WILSON. Let me give you one other piece of information that sort of lends itself to this and I can do it quickly—I guess I am using up his 5 minutes.

Mr. ROGERS. No. I used it up.

Dr. WILSON. I will quit if I am using your 5 minutes.

The fact that these hospitals are in only eight locations winds up with us having extraordinary problems about discharging patients.

Mr. ROGERS. You have 30 clinics, don't you?

Dr. WILSON. But you can't discharge a patient to a clinic in some instances.

Mr. ROGERS. In a lot of instances you can.

Mr. HASTINGS. On my original question, it apparently is somewhat difficult to come up with a cost comparison basis.

Mr. CARDWELL. I think we would have to be fair and say it will cost more per patient day in a community hospital.

Would you agree?

Dr. WILSON. Costing more per patient day is different than costing more for the care rendered. That is the problem. That is where the chairman and I are having a problem of going by each other a little bit.

We are interested in getting care to patients so that the patient is better. That unit of exposure, while it may be more per day in a hospital, may not be more for treatment per patient.

I think that is where the essence of this discussion is.

Mr. HASTINGS. One additional question: As a matter of judgment, what about the quality of care in relation to community hospitals?

Dr. WILSON. I think we make no apology at all for the quality of the exposure of the patients for the services we are able to render.

As the hospitals have become smaller, the band of services we have been able to present in a hospital have been restricted because you keep

getting fewer and fewer people so you have fewer specialists represented.

The quality of care, I think we would say, without any apology, is excellent.

Mr. HASTINGS. Thank you very much.

Mr. NELSEN. Will the gentleman yield?

Mr. HASTINGS. Certainly.

Mr. NELSEN. Expanding on the point raised by Congressman Preyer, if there is a need and the community does not want to take over the hospital, do I understand that there is no intention of closing the facility. If a negotiated understanding cannot be reached, the hospital stays there and continues to operate? Is that right?

Dr. EGEBERG. I think we would have to define that a little bit. We will see to it that the people that are our beneficiaries are taken care of. They may not be taken care of in that community because it might be more convenient for them to be cared for quite a distance away.

I would say that the other part of that need is the need of the community. We would hope to fit that need into our discussions with the community.

Mr. NELSEN. I understand. I think your answer is satisfactory. Thank you.

Dr. EGEBERG. Thank you.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I want to state that I wholeheartedly support the idea of available medical facilities serving a broad community purpose.

I heard Dr. Egeberg say, "I do not anticipate the closing, but rather the transfer to local communities of these eight hospitals."

Then I heard Dr. Wilson say there are two communities that feel they have unused beds in their area.

I also heard it said that these are antiquated facilities, and that in the past perhaps as many as 16 public health hospitals have been abandoned since World War II, or approximately that period of time.

I understand, again, that you are only in preliminary stage in this regard, but I question whether the statement by you, Dr. Egeberg, is realistic, when you say that you do not anticipate the closing but rather the transfer to local communities of these hospitals. I question this because they are antiquated, because in the past they have been abandoned, and because there are presumably at least two communities with unused hospital beds at the present time?

I can't see the people who are going to take these hospitals over.

Dr. EGEBERG. In the past, those that were chosen for closure were the ones that were antiquated and were ill used. At the present time, I don't know that one can say that any of them are antiquated enough to drop as hospitals.

You are saying that I am being inconsistent or that Dr. Wilson and I are being inconsistent together?

Mr. ROY. I thought your statement that you didn't anticipate the closing of any hospitals but the transfer to local communities was perhaps more hopeful than realistic at this time.

I am taking this out of context, Dr. Egeberg, in a sense, and I will grant you that.

Dr. EGEBERG. I have been in many of the communities and from the sounds I have heard they want them.

Dr. WILSON. One of the two communities is San Francisco where one of our best physical facilities exist. It was one of those that was modernized. One of the questions that must be answered is which facilities do you close? I don't think it is reasonable to assume that as modern as that facility is it will be one selected. The community is going to make some choices along that line. So I am not sure the statement itself is inconsistent.

I am not trying to evade the point, either. I think we have to learn more about it.

The other thing that I think is inherent in your question, if I understand it correctly, is that while we are looking at the process of turning facilities over to communities, obviously, once we have turned them over to a community we will be relying more and more on their judgment as to what an appropriate operation is.

We are not going to be closing out facilities in the early stages of this. We probably will resist any attempt to close them until they have had an adequate time to really look at the total picture.

So you have to look at it a little in a time frame of reference. The statement which some of us helped Dr. Egeberg on and discussed with him—so we bear a little responsibility as we talk about it—was addressed to the immediate future where we do not anticipate closing these facilities but instead transferring them to the local community and let them work out these problems over a longer period of time.

Mr. ROY. May I ask what local community groups you have in mind? You mentioned medical schools.

Dr. WILSON. Let me give you two or three case illustrations without, I think, burdening you with all of it.

We have talked, for instance, with the Norfolk Medical Center authority, which is not a medical school group but a hospital planning authority.

We asked them the general question of do you think you could do something like this if it became appropriate to discuss it with you?

In another instance we talked to someone in the city offices who had to do with general city planning, and we have talked to medical school people.

Mr. ROY. I don't want to get too many extrinsic factors into this, but have these hospitals been thought of in any sense by either local groups or by you gentlemen in relation to the formation of HMO's and so on in these communities?

Dr. EGEBERG. Yes, very much.

Dr. WILSON. Yes. In fact, in two or three instances, local community enthusiasm stems from the fact that this gives them an immediate chance by the location of the hospital and a number of things to use this as a focal point for the development of an HMO.

Mr. ROY. And one last question: Are we talking about transferring these without cost to community groups, or is this to be negotiated?

Dr. WILSON. I think we need to come back and tell you at a later date what those conditions are going to be. I think it would be foolish now. Whenever you start to work with somebody else you have to have all the details laid out before you determine whether or not it is going to cost you anything.

I think that is part of the discussions as you get into planning.

Mr. CARDWELL. I think he gave you exactly the right answer. But I would underscore two points made by Dr. Egeberg in his statement.

In the negotiations we are prepared to maintain some flexibility on the concept of keeping some of the Commission Corps personnel where they are for some transitional period. That is a benefit.

Also, we would negotiate the cost and operation of special service departments that are extraordinary, and the maintenance of the research activities that are in place in some of the hospitals.

All three of these factors could give the local entrepreneur some benefit.

Mr. ROY. You said special departments such as coronary care units, kidney dialysis units, and so forth, should continue. What is the basis of that?

Frankly, it appears to me to be a premature decision if you are going to be associated with a medical school, for example, in a metropolitan area.

Dr. EGEBERG. We feel there are some clinical research projects involved in coronary care for one example, arteriosclerosis being another one, and we also have some primarily service projects.

If you have a kidney dialysis unit you have assumed a responsibility to a small or a broad community.

What we mean there is that we will continue making such service available in that hospital or see that it is established in another one.

Mr. ROY. I realize it is "should" instead of "will continue."

Dr. EGEBERG. Yes.

Mr. ROY. Thank you.

Mr. ROGERS. Who made the decision, who initiated the decision, that the hospitals would be closed as reflected in the budget? Was this initiated by HEW?

Dr. EGEBERG. This came out of HEW. We have been discussing this off and on. But I don't think we have initiated a decision that the hospitals really should be closed. We have initiated the decision to make a definitive study to find out whether they should be closed.

Mr. ROGERS. There is no point in our sparring around. If there is no money in the budget, are you going to put it out of your pocket, Dr. Egeberg, or is the Secretary, to keep them going?

Mr. Cardwell we might as well get down to it. Is this a budget decision or is it HEW's?

Mr. CARDWELL. I think we could review the bidding and chronology of events as best they can be reconstructed. In the original HEW budget submission to the Office of Management and Budget, we did propose a concept which would have converted, we suggested, five of the hospitals and retained three.

Mr. ROGERS. What were your budget figures for that?

Mr. CARDWELL. I can't give them to you right off the top of my head.

Mr. ROGERS. Would you supply those for the record?

Mr. CARDWELL. Yes, sir.

(The following information was received for the record:)

BUDGET FIGURE FOR FISCAL YEAR 1972 (5 HOSPITALS CONVERTED AND 3 HOSPITALS RETAINED)

Under the assumption that only five hospitals would be converted to community use and control, and three hospitals would be retained and operated by DHEW, it is estimated that the cost in Fiscal Year 1972 would be $73,000,000.

Mr. ROGERS. Then what happened?

Mr. CARDWELL. Then as we evolved the budget, and this not an arm's length arrangement between OMB and HEW, rather there is a great deal of give and take.

Mr. ROGERS. Mostly give, I think.

Mr. CARDWELL. It depends on which side you are on.

Mr. ROGERS. I was speaking for you.

Mr. CARDWELL. Halfway through this process, word got out that we were going to decide to close the hospitals. It was at that time that the House Committee on Merchant Marine and Fisheries started asking us questions as to whether we were planning to close the hospitals.

I would have to suggest to you that that did have an impact on the final process. The Office of Management and Budget, I think, in order to provide the impetus for the kind of thing we are now embarked on, did make a budgetary decision and did say "We are going to remove from the budget the savings that could be realized if you went to the second alternative in its entirety, providing that that alternative relied heavily on the Veterans' Administration." And that is the budget that was sent to Congress.

Also, in this give-and-take the Secretary developed an understanding with Mr. Shultz and the staff of the Office of Management and Budget that no matter what happened if, as we evolve this thing, we found that assumption to be faulty or we found that you had to significantly increase the cost of operations, that the budget would be amended at no cost to HEW. That is a very clear understanding that we have with the Office of Management and Budget.

Mr. ROGERS. When would it be amended?

Mr. CARDWELL. I would guess that it would be amended probably late next fall, or sometime thereabouts. It could be in the form of a supplemental or it could be in the form of a budget amendment, depending on the status of the budget at the time we reach our final conclusions.

As has been said here this morning, we don't expect to reach final conclusions until either late in the current fiscal year or early in the next fiscal year.

Mr. ROGERS. As to whether the hospitals would continue or not?

Mr. CARDWELL. As to whether the budget would require an amendment.

Mr. ROGERS. We know the budget is going to require amendment if you make a decision to continue the hospitals, don't we? You know that.

Mr. CARDWELL. The budget could require an upward amendment under either of two circumstances: A decision to continue all or part of the hospitals at their present operative level under our auspices into fiscal year 1972 could increase the budget. If we were successful in arranging conversions and the cost of the conversions including the cost of providing contract care were greater than the present budget

estimate for this program and I assume, frankly, that it would be, that would force a budget amendment.

Mr. ROGERS. Have you figures of what you consider contract services would cost if you had to contract all of these services?

Mr. CARDWELL. We do not at this time. It all depends on these negotiations that would take place in the local communities and among those who might provide services. We could give you an estimate of what we tentatively expect that it would cost to provide all of the current care on a contract basis.

Mr. ROGERS. What figure would that be?

Mr. CARDWELL. It would be in excess of $100 million.

Mr. ROGERS. $100 million?

Mr. CARDWELL. That is right.

Mr. ROGERS. That is by contract, is it, or is that including VA?

Dr. WILSON. No, that is if you totally went to the private market and you had the same numbers of patient days of care. That is one of the issues why you have to give a soft answer to that question.

Mr. CARDWELL. If we went totally to VA, the figure would be below the budget that is now before you. If we went predominantly to VA you might well be at the budget figure, which is a reduction of $14 million below last year's costs.

Mr. ROGERS. I have figures that in 1970 there were 392,000 hospital days for the primary beneficiaries. Is that approximately correct?

Dr. WILSON. Yes; 392,000 is correct.

Mr. ROGERS. Wouldn't you think the contract services generally would run probably $100 a day?

Dr. WILSON. No; this is where you and I keep talking past each other. A substantial amount of that would be nursing home care and would be handled in extended care rather than in the intensive care.

Mr. ROGERS. All right. Cut it in half. Say half of it was for nursing homes.

Dr. WILSON. It may be even less than that with a 17-day stay.

Mr. ROGERS. Don't you think cutting it in half——

Dr. WILSON. No, I wouldn't except half.

Mr. ROGERS. All right, cut it two-thirds. What is two-thirds of 392,000—it is about 160,000, isn't it? And $100 a day for 160,000 hospital days, that is cutting two-thirds, which comes out in my mind to about $160 million, not $100 million.

Dr. WILSON. $16 million.

Mr. ROGERS. I may be in error, Doctor, but I believe it is $160 million. What does your finance man say?

Dr. WILSON. I say $16 million.

Mr. ROGERS. It is 160,000 times $100.

Dr. WILSON. Which is $16 million.

Mr. ROGERS. You are right, $16 million. I am sorry.

You have 237,000 hospital days for all other beneficiaries, is that correct?

Dr. WILSON. You are right. You have done a subtraction there and that is right.

Mr. ROGERS. Is that correct?

Dr. WILSON. That is correct. We would expect that to follow the same proportion.

Mr. ROGERS. Cut two-thirds from that. What will that be?

Dr. WILSON. Between 8 and 9 million.

Mr. ROGERS. You have outpatient visits, 712,000 for primary beneficiaries. What do you get those for? Would it average out to about $25 a day outpatient?

Dr. WILSON. No; it doesn't run that high. I think, Mr. Chairman, that although we have talked about conversion of this, one of the things staff needs to look at pretty intensively is whether the clinics in this discussion will finally be lumped with the hospital operation. There is an issue here of meeting the needs of the seamen that we need more time to look at. Outpatient visits, I believe, are running somewhere between $15 and $17 for this kind of outpatient visit in the community hospital.

Mr. ROGERS. That is $15 and $17 in a community hospital?

Dr. WILSON. For this kind of visit. Many of these are for preventive care for dependents.

Mr. ROGERS. That would be the average?

Dr. WILSON. I am giving you an off the top of my head answer.

Mr. ROGERS. Could you get us more specific figures and supply them for the record?

Dr. WILSON. Yes; to compare to this population.

(The following information was received for the record:)

1972 PROJECTED CONTRACT CARE COSTS FOR TREATMENT OF PATIENTS FROM PHS FACILITIES

	Assumption No. 1 [1]	Assumption No. 2 [2]
Primary:		
Total cost	$69,614,671	$54,620,759
Inpatient	53,663,996	40,612,314
Outpatient	15,950,675	14,008,445
Nonprimary:		
Total cost	57,319,283	46,394,679
Inpatient	32,483,933	24,583,404
Outpatient	24,835,350	21,811,275
Primary and nonprimary:		
Total cost	126,933,954	101,015,438
Inpatient	86,147,929	65,195,718
Outpatient	40,786,025	35,819,720

[1] Inpatient—1970 experienced patient days at $137 per day; the 1970 experienced rate of $125 is projected to the estimated 1972 level. Outpatient—Experienced visits at $25; the 1970 experienced rate of $22 is projected to the estimated 1972 level.

[2] Inpatient—72 percent of patient days in ecute general cere hospitals et $137 per day; 28 percent of patient days in exfended care facilities projected at $18 per day. Outpatient—Approximately 80 percent of visits at full $25 rate each and 20 percent of visits at lower cost rate of $10 each.

Note: All amounts include physician and laboratory fees.

Mr. ROGERS. Now you have 1 million days for all other beneficiaries, outpatient visits.

Dr. WILSON. We are collecting now for many of those because many of those are military dependents and others. So that money comes through and changes hands.

Mr. ROGERS. Would you let us have those figures too?

Dr. WILSON. Yes. (See table above.)

Mr. ROGERS. So the total number of hospital-days for all beneficiaries was 628,817. Is that correct?

Dr. WILSON. For the others.

Mr. ROGERS. And 1,633,000 for outpatient visits in hospitals and clinics.

I would like for you to furnish for the committee the actual figures that you project of costs.

Dr. WILSON. Fine. (See table on p. 36.)

Mr. ROGERS. Dr. Egeberg, what do you see as the role of the Public Health Service Commission Corps?

Dr. EGEBERG. Well, I see that in many different ways. The Public Health Service, the Commissioned Corps, has in the past probably been responsible for saving more lives than the physicians in practice. But times have changed, and much of the work that the Commissioned Corps has done in the past is now being done by other people, whether they are in State health departments or whether in a much more technical job. I see in the future that the role for a group of people, Commissioned Corps or other corps—and I am just keeping my mind open in making my statement this way—is going to have much more to do with the delivery of health care to individuals than it is in the broader sweeps. It also has the overall view of the epidemiology of this country and of the world, the gathering of statistics that help us know where we are. But the real impact has to be in the care of people, and the care of people in areas where it is hard to have them cared for, which means slums and far off rural areas. I would feel that that is where the next great opportunity, the next great challenge, and the next great job of import is, in seeing that the distribution of health care is made equal for everybody in this country, both as far as access is concerned and as far as the quality of care once they get it.

Mr. ROGERS. Let me ask you this: Do you think if you are going to have a Commissioned Corps that it is necessary to have hospitals and facilities where you train them, bring them in, recruit them, carry on specialized programs, do innovative work? Is that helpful, or not?

Dr. EGEBERG. Well, in ways it is helpful. It gives them a place where they begin to feel at home as they come in. The trouble is that most of those people leave as soon as their 2 years are up. I would say that in looking at the overall problem it is so much broader and involves hospitals in so many more places than where they now exist that one has to keep an open mind about that. The Commissioned Corps needs will be great in some of the areas where the hospitals exist.

Mr. ROGERS. I am thinking of training for the Corps itself, Doctor.

Dr. EGEBERG. Training to get the feeling of the Corps, itself?

Mr. ROGERS. You need some residences and internists, and so forth.

Dr. WILSON. Allow me to give you one case in point, I think, that speaks to the concern you are expressing. That is the University of Washington, at Seattle, where a substantial amount of the Public Health Service Corps residency training is conducted under those auspices and, in fact, part of the time, at the University of Washington Medical School Hospital on an exchange basis.

We would anticipate that as we develop fiscal relationships with whomever takes care of our primary beneficiaries, that with that goes the chance to talk about our needs for training and that the training would be under the auspices of the academic institutions there as well as ours, just as we have been doing at the present time.

May I make one other comment to this? We have another problem if you try to project over the long haul with the Commissioned Corps

as it relates to physicians. Sixty-five percent of our physicians are 2-year men, drafted individuals, which provides us with some concern as you project this over the long haul, and we listen to discussions about the future of the draft. Forty-five percent of all of our commissioned officers are 2-year people. This is outside of the physicians, including everybody. PHS hospitals are a large but only roughly about a 20-percent user of the Commissioned Corps. As I recall, the total use of the Commissioned Corps by the PHS hospitals is 1,400. Well, even that is not quite right. It is a little below that. It is about 1,200 out of 5,500.

Mr. ROGERS. Isn't it true that you have seven applications for every vacancy you have in the Public Health Commissioned Corps?

Dr. WILSON. That is in the 2-year group, not in the career or long term. Of that 2-year group, only a little less than 5 percent really stay on as career people. It is quite obviously a draft alternative which has advantages for them and through this alternative we will continue to be able to get them.

Mr. ROGERS. It has advantages for you. I don't know how else you could get them, do you?

Dr. WILSON. No, I don't.

Mr. ROGERS. Of course not. It is a great advantage for you, and you have had great response.

I have gone over the study that the Secretary talked about, sending out teams to see whether this ought to be done or not, the overall summary and individual hospital summaries, which I appreciate your furnishing to us. "Site Visits January 18–22" (see p. 69, this hearing).

I don't see one recommendation in here, or one conclusion of fact that would warrant the closing of any of these hospitals. Do you?

Dr. WILSON. No, and I don't believe we are proposing at the moment to close them. We are proposing that as the number of primary beneficiaries goes down and the usefulness to the community goes up, we perhaps ought to look at how the management is handled.

Mr. ROGERS. Let's start getting into some specifics. There is all this talk of "We are going to decide later," but there is nothing in the budget. You take the facts brought out here and every one that I read, and here is what it says—and your people didn't even get with your planning community or comprehensive planning down there. In New Orleans they were very upset about it. Here we are supposed to have set up comprehensive planning for the areas, but they have had no inputs to this, and yet there is no money in the budget to continue these hospitals.

Dr. WILSON. They were invited to the visits.

Mr. ROGERS. On Friday, for Monday.

Dr. WILSON. As everyone else.

Mr. ROGERS. This committee invited the Secretary a week ago, and tried to change our date. We were going to have it Wednesday. I would say you at least ought to give them a week.

And that is supposed to be their inputs.

If you will, read what your study says. Have you had an opportunity, Doctor, to read this report?

Dr. EGEBERG. I have read it in part. I haven't read the whole thing in thorough detail.

Mr. ROGERS. Have you, Mr. Cardwell?

Mr. CARDWELL. Yes, sir.

Mr. ROGERS. You have read it all?

Mr. CARDWELL. I have read it; yes, sir.

Mr. ROGERS. Do you know what it said in each community that they went to? It said the Public Health Hospital is an important and integral part of the local health care system; that communities questioned the inference that closure of the hospitals will bring in Federal savings.

Do you really believe, Mr. Cardwell, it would bring in Federal savings, honestly? That is when you know you are going to have to supply services, either by contract or some other way.

Mr. CARDWELL. Mr. Chairman, my personal and candid opinion is that we are going to have to amend the budget now before the Congress before this is all over. That is the only way I know to answer your question.

Mr. ROGERS. Well, you don't think it is going to make real savings?

Mr. CARDWELL. The word "savings" is a very relative thing. You can count savings in the pennies that you count up or you can count them in terms of how effective things are.

Mr. ROGERS. Let's look at it the way the budget does; money figures. There will not be any reduction there, basically. Probably it will cost more.

Mr. CARDWELL. As the Secretary, I think, has said, and Dr. Egeberg said in his statement, the savings for savings sake is not our objective here in terms of dollars.

Mr. ROGERS. It is not yours, but it is the Budget's, I am afraid.

Mr. CARDWELL. I think we persuaded the Office of Management and Budget that a better policy would be a policy directed toward better care and an assurance that no community loses because of any change we make.

Mr. ROGERS. Let me read from your report here:

"The quality of care provided at the hospitals is generally considered excellent."

You are going to provide better care? It is excellent now.

Dr. EGEBERG. We can always provide superior care.

Mr. ROGERS. Would you name me the hospitals that supply superior care vis-a-vis excellent care, Doctor?

Dr. EGEBERG. No, thank you.

Dr. WILSON. That is his task, but let me respond in another vein, if I may. I think I have testified earlier that we have said the quality of that care is excellent. The spectrum of care that we are able to present, as the census goes down, is receding because you can't keep the staff it takes to give a broad band of service. What Dr. Egeberg is saying is that if a patient meets a physician in the hospital, the result is good care, but we are having fewer and fewer circumstances that make it feasible to bring patients in to some of those hospitals that are getting small.

Mr. ROGERS. I am sure you realize that Congress has just expanded the authority of the Public Health Service to provide expanded care.

Dr. WILSON. Yes.

Mr. ROGERS. Are you aware of that bill we passed?

Dr. WILSON. We quote it, I think.

Mr. ROGERS. In spite of HEW, the President signed it.

Dr. WILSON. It has our enthusiastic support.

Mr. ROGERS. It didn't before this committee. You know that.

Dr. WILSON. I wasn't here.

Mr. ROGERS. Well, you haven't been briefed fully, then, Doctor. But I am glad you are supporting it. I know basically in your hearts you all felt it was right, as somebody once said.

Nevertheless, what I am concerned with is that we are expanding your role. We have said now with the Emergency Health Personnel Act we want you to have an expanded health facility, and if you are going to expand the role you are going to need facilities to do that. There is no reason why, as you say, a lack of beds capacity can't be rapidly filled by an expansion of service that we envisioned in passing that act. I am sure as you implement the act, which you haven't had time to do yet, but we hope a supplement will come in on that——

Mr. CARDWELL. It will come in the 1972 budget; yes, sir.

Mr. ROGERS. That is encouraging. How much will come in?

Mr. CARDWELL. Our present plan is for a $10 million budget amendment, as the President announced in his health message.

Mr. ROGERS. I commend you. I think that is excellent. We will even commend the Budget on that, the Office of Budget and Management. That is excellent.

I know it took some work to get that done once the law was passed. That is excellent.

Now, this will give an added reason to keep these facilities within the Public Health Service because you are going to need some facilities to do this kind of care.

Dr. EGEBERG. If I may speak to that a second, the reason I have expressed myself even prematurely, I guess, as enthusiastic about that act and its potential is the fact that it does allow us to use people in slums and in areas where the need is great as long as they are working under Public Health Service supervision. It is this breadth and reach which probably won't relate too often to a Public Health Service hospital. These people will be trained people who will have come out of an internship at least and possibly out of part of a residency. So in areas the Public Health Service hospital might well fit into the picture. But the picture is broader than that. It is the local community hospital or the local county hospital that we are going to be working with to a greater degree. Anyhow, I want to express my gratitude for that bill.

Mr. ROGERS. Thank you, and we appreciate your implementing.

Take what you have just said. Take Texas—Galveston, Tex. If we close the facility there the president of the university says it will cause—and it is in your report—a drop of 20 percent in their training program. Here we are right on the verge of trying to get into health manpower legislation.

I see Dr. Zapp here, and I hope he is going to talk to you about not letting any reduction of training come about, training which has been coming from these Public Health hospitals.

Dr. EGEBERG. Galveston is the one that is 84 percent full, I think.

Mr. CARDWELL. It is 78 percent full.

Dr. EGEBERG. If it is that full, one would certainly find another arrangement, probably in that case in connection with the university.

Mr. ROGERS. But this is not so in the budget, Doctor, the budget situation as presently existing. That is what I want to come to today.

Can you give us assurances that we don't have to wait until October? Why can't the decision be made now to come in with a supplemental? You have to keep these hospitals going, you know, for the rest of the fiscal year coming up. You can't make any adequate changes or arrangements, we know that; you know that. But the people in the Public Health Service are entitled to know that as well.

Young men who want to come into the Service are right now making decisions whether they will intern or try residency in these hospitals. They have to make their decision in March or else they are going to be out. There are just not places to go for so many of these young men and women who are trying to become doctors. We need health manpower as called for by the President.

I think the Department is under an obligation to give some assurance to these thousands of people who are involved as well as to the almost 2 million, or over 2 million, beneficiaries. This shouldn't be left in limbo with the Budget saying one thing and HEW saying "Well, we are still studying and don't know."

Could you comment on that, Mr. Cardwell?

Mr. CARDWELL. It will be a comment. I don't really think I can give you the brands of assurance you are really asking for.

Mr. ROGERS. Can you get it for us?

Mr. CARDWELL. Let me tell you the assurance that we can give you and give it to you today, and I think it represents the maximum assurance that the administration is prepared to give at this time. That is, one, we will keep the present facilities and the present staff in place at full scale operations until the alternative is identified.

The outlook at the moment is that that alternative would keep the facilities themselves in operation, and that their current employees would not be disadvantaged by our decision.

Point No. 2, is that we will make the budget whole once we know just what it is that we are going to propose to Congress, and whatever it is we propose will be matched by dollars, and will be reasonable and as effective and efficient as we know how to make it. We can give you that assurance. We can also assure you on a third point, and I would like Dr. Egeberg and Dr. Wilson to comment on this if they in any way disagree with me: That is, that we will recruit at full scale Commissioned Corps personnel into the system. I don't think we can assure you that the present situation doesn't cast doubt for them, and I can't assure you that it wouldn't have some effect on that recruitment. But our efforts will be real and significant and will be full scale.

Dr. EGEBERG. I agree with that.

Dr. WILSON. I agree.

Mr. ROGERS. I appreciate that comment. I realize the constraint under which you would make a commitment. But I would like for you to ask the Secretary to assure this committee in writing that budget requests will be made to continue the hospitals in the present setup as stated, so that we will have something to assure all the people involved. I think this is very essential.

I am concerned also about some of the other services. I don't think you will find that communities will be able to do all this. Suppose a community decides to take it over and then it doesn't have money to run it? What happens then? If you don't think you can run it, how do you think the communities can run it?

Dr. WILSON. I don't believe it is a matter of whether we can run it or whether the community can run it. In Dr. Egeberg's statement, and I think Mr. Cardwell has repeated it in a different way, it was stated that we will continue to provide the HEW budget support for the people for whom we have an established responsibility. We are not talking about not providing that.

Mr. ROGERS. This concerns me even more to hear you talking this way. You are talking about the possibility of closing out the facilities, then, and losing the hospital beds and so forth?

Dr. WILSON. No, that wasn't what I said. You are asking how a community managing it could meet the cost, how would they come up with additional money.

Mr. ROGERS. Yes.

Dr. WILSON. All I am saying is that nothing that has happened to date would indicate that they had come up with additional money.

Mr. ROGERS. In other words, you will still have costs attendant to carrying on the hospital?

Dr. WILSON. Yes, for the beneficiaries.

Mr. ROGERS. Then what is the saving? If you are going to have to go in and supplement the running of the hospital for the community, I don't know any community that will take over a hospital that you say you wouldn't want to run and then expect them to bear all of the expense.

Dr. WILSON. We are assuming that the community which has hospital capacity need for using the other 30 percent of those beds will be generating income from other sources than ours, and that they will indeed have additional income from those sources.

Mr. ROGERS. Sufficient to carry on the hospital?

Mr. WILSON. With us paying for the beneficiaries for whom we are retaining the fiscal responsibility.

Mr. ROGERS. All you have to do, then, is just fill up the rest of your beds and they still couldn't match it if you used the Emergency Health Personnel Act.

Dr. EGEBERG. The point, I think, would be that as the curves indicate and as the present situation indicates, we would be running a hospital where our beneficiaries would only represent 35 to 40 percent of the patients, if the hospital were being run efficiently and at full capacity. That raises one of the questions we are looking into. Would it be appropriate to run a hospital where our beneficiaries only represent one-third to 40 percent of the patients?

Mr. ROGERS. The hospitals where you are now located have your beneficiaries higher than that. You say occupancy is up to 70 and 89 percent.

Dr. EGEBERG. Those are not our beneficiaries.

Mr. ROGERS. Then how do they get into your hospital?

Dr. EGEBERG. Because we are stretching and taking care of secondary and third——

Mr. ROGERS. I disagree with that. You don't mean you are letting people go into your hospital that are not authorized to go in?

Mr. CARDWELL. I think the figures work a little bit like this, if you look a little into the future. If you examine the system as a whole, and if the present trend continues, we would find that our beneficiaries would account for about 40 percent of the total capacity of the sys-

tem. You have suggested why not fill up the difference with community clients using the authority of the Emergency Health Act of 1970. What Dr. Egeberg is saying, if I can sharpen the focus, is that if you reach that point then it may not make sense that the Government should be the operator of that hospital. It might make more sense that the people represented by the 60 percent should operate it and we should become a client rather than the owner and operator.

Mr. ROGERS. What are you going to do about your training programs, your research programs? What about at San Francisco? They have a consortium there.

Mr. CARDWELL. We have said that one of the conditions that would be a basis or underlie our negotiations would be that we want to continue in place such arrangements.

Mr. ROGERS. Every time we come to these negotiations, you are sweetening a little more, a little more Federal funds, the carrot becomes a little larger. It looks to me like you are getting back to the point where you are spending that and paying contract services over and above what you will have to do to maintain the hospitals anyhow. No one is just going to take over these hospitals, you know that and I know it, because they cost money. What incentive is there, unless you agree in your negotiations that you are going to pay some of those hospital costs? I don't see any incentive.

Dr. EGEBERG. You were talking a few minutes ago about the question of savings. Sort of like from right-hand pocket to left-hand pocket. Many of these people who are beneficiaries also are beneficiaries of medicaid and medicare and private insurance. Whether we pay for it through one or another, or whether they provide for payment through their private insurance, it seems to me that in the overall the savings aren't going to be very marked one way or another, retaining or giving.

Mr. ROGERS. I am concerned about that now because the intent of the Congress is clearly stated in the law, what the obligation of the Public Health Service is to beneficiaries.

Dr. EGEBERG. Yes, sir.

Mr. ROGERS. You are now saying that you are going to let medicare or somebody else take care of them.

Dr. EGEBERG. No, we aren't. But they might well choose to go to a hospital that is more convenient for them and have payment provided by some other means.

Mr. ROGERS. And then we are going to be paying so they can go either way, is that what you are telling me?

Dr. EGEBERG. Yes. We are maintaining the responsibility to see that they get as good as or better care than they are getting now.

Mr. ROGERS. So you are not going to provide the Public Health Service? You will say they can just go without——

Dr. EGEBERG. No, we are going to provide them with the care, but often it is a matter of how far away geographically that care is at the present time.

Mr. ROGERS. In Galveston, they would have to go a long way, for instance, with VA, if you work it out, to get in there.

Do you know what the situation is in Boston Hospital on beds?

Dr. EGEBERG. Do you mean whether they have enough hospital beds in the city or region?

Mr. ROGERS. Yes.

Dr. EGEBERG. They ought to come closer to it than most places because I don't believe they have been growing as fast as some of the others.

Mr. ROGERS. Dr. Andrew Sacket, commissioner of health and hospitals in Boston, opposes the closure of the hospital there and said that the State hospital planning agency shows a shortage of 700 beds in the Boston area. There is a 2- to 6-week wait for elective admissions to hospitals in Boston. Hospitals in the Boston area simply cannot absorb the patient load of PHS beneficiaries that are now hospitalized in the PHS hospital.

You can go down the line on some of these, cutting out training, as you will affect the University of Texas. I don't know if a community hospital would want to agree to that. Certainly, the University of Texas will not take over that hospital unless you paid the cost of the hospital. If they did, it wouldn't make much sense.

I think we better find out what you are doing in negotiations and what all of the centers are so that this committee can make some intelligent judgments.

Dr. EGEBERG. We haven't done any negotiating yet. We are trying to get the facts.

Mr. ROGERS. You have already said you were closing them.

Dr. EGEBERG. Not closing. I want to get that word out of here.

Mr. ROGERS. You may not say so, but the dollar figures in the budget say no money after July of this year.

Mr. CARDWELL. We have said repeatedly that the budget is also prepared to make whole whatever adjustments we make.

Mr. ROGERS. When? In October, maybe. Well, that doesn't answer the question of whether you are keeping the facility or not. We need to know ahead of time because we will introduce legislation to prevent it.

Mr. CARDWELL. Could I comment on the Boston example?

Mr. ROGERS. Yes.

Mr, CARDWELL. I would guess from the statistics I have before me that there are probably somewhere between 25 and 30 vacant beds in the Boston PHS hospital on an average day. If that were converted to community use, Dr. Sacket would pick up those beds for his use.

Mr. ROGERS. Under the Health Emergency Personnel Act you can do that. So that answers that question. This is what we intend to be done. We want the Public Health Service to be active. They have to be trained somewhere.

I understand the whole situation, and I understand your positions, but I think when we really see the dollar figures I think when the Office of Management and Budget, when you show these figures to them, will come around to the feeling that we should keep these open for the service that the people are entitled to by law.

You say that a lot of these would need modernization. Who will assume the cost of the modernization if you turn them over?

Dr. WILSON. If title is transferred they become eligible of course for grants under the Hill-Burton Act, or ambulatory or hospital care. They become eligible for loans.

Mr. ROGERS. What are they going to have to pay back the loan with?

Dr. WILSON. One of the points I would like to add, if I may, is that when we operate the hospitals we are not privileged to collect for medicare patients for a variety of reasons. I suspect that between that as an added amount of money that becomes income to the hospital——

Mr. ROGERS. Maybe we ought to change that and let you do it. Do you think it would be a good idea?

Dr. WILSON. One I think always gets back, Mr. Chairman, to the discussion of whether if 40 percent of the beneficiaries, and this is a declining percentage, which is continuing to go down, are our primary responsibility, and the balance the community's, should be trying to run the facility in behalf of the community.

Mr. ROGERS. The Congress has given you the responsibility to do it.

Dr. WILSON. And, we will continue to do it until we have worked out something.

Mr. ROGERS. The Congress hasn't said for you to work out anything. The Congress said to run this and to provide this service. This has been done for some 163 years.

Dr. WILSON. I would think, Mr. Chairman, and I hope you would accept this as I mean it, I would assume that as responsible administrators we have a continuing responsibility to look at what we are doing, keeping our beneficiaries in mind, to be sure we are, in fact, giving them the best possible care. Finally, we must discuss with you the fiscal implications, the program implications, and that is what we are doing today. But I don't believe you would want us not to be doing the kind of review we are doing so that we are all better informed.

Mr. ROGERS. It is nice to be informed, but there you have a report that doesn't recommend the closing and yet the budget reflects it.

Dr. WILSON. That kind of question I always defer to Mr. Cardwell.

Mr. ROGERS. Let me get to the 40-percent figure that you say is declining. When we passed the Emergency Health Personnel Act, I think you are going to find that that is going to increase the responsibility of the Public Health Service.

Dr. WILSON. The 40-percent figure—I wouldn't want to deceive anyone with that—relates to the merchant marine and Coast Guard and does not relate to the balance or the people for whom we are giving care.

Mr. CARDWELL. Mr. Chairman, you have made the point now several times that we could make up the difference. You have said to us, "If you are really basing your case on underutilization of hospital beds, why not fill them up with the community patients and use the authority of this new act?" What we have tried to say in response to that is that if you look down the road it would suggest that we are going to be the minority client in each of the facilities. Doesn't that suggest that the people representative of the majority should be in charge of the hospital? That is one reason why we think we ought to continue to explore that alternative, the alternative we have mentioned here today.

Mr. ROGERS. The Public Health Service has responsibility not only to the merchant marine and the Coast Guard, but it is responsible for leprosy patients, for the care and treatment of Federal prisoners——

Mr. CARDWELL. No change would be made in those two situations.

Mr. ROGERS. Let me finish. The examination and treatment of Federal employees, the examination of aliens, the treatment and rehabilitation of narcotic addicts.

Dr. WILSON. Those are all continuing. They are not really involved in this. The Lexington Hospital is operative in one instance, and our Federal employees' program under Dr. Butler is quite a different program from the PHS hospitals.

Mr. ROGERS. You also have the Indian health.

Dr. WILSON. And we are still operating that.

Mr. ROGERS. I understand. And the Eskimos.

Dr. WILSON. We are still operating a program for them.

Mr. ROGERS. And your Federal Health Program Service.

Dr. WILSON. That is all operative. That really doesn't relate to this set of discussions.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Mr. Carter.

Mr. CARTER. I would like to ask what percentage of your Commissioned Corps actually are trained in Public Health Service hospitals?

Dr. WILSON. I don't believe we can answer that question. I guess that might take a bit of doing, but we can get it for you.

(The following table was received for the record:)

SPECIALISTS EMPLOYED AS OF MAR. 8, 1971, IN FEDERAL HEALTH PROGRAMS SERVICE HOSPITALS AND CLINICS

Specialty	Anesthesia	Dermatology	Internal medicine	Neurology	Ob-Gyn	Ophthalmology	Orthopedics	Otolaryngology	Pathology	Pediatrics	Psychiatry	Radiology	Surgery	Urology	Total
TRAINED INTRAMURALLY															
Years of service:															
0 to 2															
2 to 5	2	1	6		1	1	1					2	1		15
5 to 10	2	1	22	1		6	4		1			3	8	2	50
10 plus	1	4	23	1	1	2	2		4		1	4	16	2	61
Subtotal	5	6	51	2	2	9	7		5		1	9	25	4	126
TRAINED EXTRAMURALLY															
Years of service:															
0 to 2	7	2	27	6	1	7	6	3	12	9	6	10	3	4	103
2 to 5		1	8			1			3	2	2				17
5 to 10			3					1		1	2		2	1	10
10 plus			4		1	1		4		1	2		1		14
Subtotal	7	3	42	6	2	9	6	8	15	13	12	10	6	5	144
Grand total	12	9	93	8	4	18	13	8	20	13	13	19	31	9	270

Mr. CARTER. Isn't it true that in the U.S. Public Health Service hospitals we have patients admitted regularly in the off season and older seamen really go to places called Snug Harbor in these hospitals? Is that true?

Dr. WILSON. Well, you stated that. I guess we would have to say that that might well have a relationship to the days the patients stay.

Mr. CARTER. Actually, some of these older merchant seamen think the hospitals are places to rest for a while, and the name of such area is usually referred to as snug harbor? Isn't that true?

Dr. WILSON. You are better informed than I as to the use of terms. But I would say if there is illness involved we would be quite charitable with people like this.

Mr. CARTER. To my knowledge you are charitable, and there are certain places where this is so in at least some of the hospitals, and I feel many of them.

Thank you, sir.

Mr. ROGERS. Evidently the approach has been on a statistical basis, the cost-benefit ratio. I am afraid we get so involved in this that we have a tendency to overlook the individuals who are entitled to this service and what this means, and also the individuals in the Public Health Service and what it will mean to the morale of that Public Health Service.

I would like your figures, if you would let us have them with the names, of each facility that it is proposed be closed by the Budget figures.

I understand you are going to try to get a statement saying you will come in. I would hope this would be done very shortly. In fact, if the Secretary would like to appear, we would like to invite him. We will be meeting Tuesday, Wednesday, and Thursday of next week. I think it would be reassuring to those involved if he could come in and say "We are now asking for these facilities to be funded."

I would like the names of all of the hospitals, the basic facts on them, patient load and so forth, cost, for the record. Also, I would like all of the clinics to be listed, with patient load, and so forth. I would like to see proposed plans for the use of health personnel of the Public Health Service Corps. I think in your projections, and I am sure you will go through it, I would like to see how manpower will be handled, what would happen, where they would be used or not used. Then I would like for you to give us any negotiated provisions that you have carried on with anyone as to encouraging them to take over these hospitals.

Mr. ROGERS. Has there been any request for anyone to take over any of these hospitals?

Dr. WILSON. No. All of those discussions have been handled, I think, by me personally with community people at this level because I wanted to be very careful there was no implication that we were asking anyone to do anything. All we wanted was a comment upon this kind of a principle. We have repeatedly, with other people present, made sure that every one understood we were not talking about a negotiation. We were simply talking about a principle of approach.

Mr. ROGERS. If you decide to keep these facilities, would you have to come in for modernization? Mr. Cardwell may know that.

Mr. CARDWELL. Well, they keep giving me all these money questions. I am going to pass one back to them in a minute.

I will take the first part of the question. I would think if Dr. Egeberg and the health professionals in the Department reached the conclusion that in order to assure that the quality of care to which the beneficiaries were entitled is to be maintained, required modernization at some point in time then I think the decision would have to be that we would have to budget for it.

Mr. ROGERS. The Congress has previously authorized that.

Mr. CARDWELL. The Congress has actually appropriated something in excess of $6 million to plan the modernization of these facilities. Some of that money has been spent, as the chairman knows, and some analyses have already taken place. But no money has been appropriated thus far, or requested thus far, for actual modernization. I think the basic question here is one of what does it take in order to assure over the long term that quality care can be provided. That is a question that Dr. Egeberg or Dr. Wilson must answer.

Dr. EGEBERG. I don't think we would continue the hospital if we couldn't provide quality care within the realm of the care we are providing. It would be more a question of efficiency as far as modernization is concerned. That becomes a matter of the budget. Obviously, if modernization is necessary to see that we give the best care, then even if we only expect to hold a hospital another year or so we are going to do that. But it would be a matter of efficiency more than of the level of care. It takes more people to provide good care if you don't have a modern hospital.

Mr. ROGERS. I also think it would be well for us to have what is the projected cost for modernization of the hospitals as well as today's costs for replacement of the same number of hospital beds, if we can have those figures.

(The following information was received for the record:)

Summary information on PHS hospitals and clinics

Population of primary beneficiaries eligible for care:	
American seamen	207,200
Coast Guard	37,300
Public Health Service commissioned officers	5,900
National Oceanic and Atmospheric Administration (Coast and Geodetic Survey)	900
Total	251,300
Workloads affected by closures (8 general hospitals and 30 outpatient clinics):	
Total average daily patient load (635,010 patient days)	1,735
Primary beneficiaries (392,352 patient days)	1,072
Other (DOD, dependents, etc)	663
Total outpatient visits	1,769,270
Primary beneficiaries	646,343
Other (DOD, dependents, etc)	1,122,927

Personnel affected by closures:	
Total	5,362
Commissioned officers	1,210
Medical	731
Dental	144
Dieticians	34
Medical record librarians	22
Pharmacists	109
Physical therapists	62
Engineers	23
Social workers	15
Other	16
Civil service	4,162
Nursing	1,049
Dietary	512
Housekeeping	278
Laboratory	231
Radiology	117
Engineering and maintenance	328
Medical records	182
Outpatient clinics	588
Other	877
Current budget (appropriated funds anticipated fiscal year 1971):	*Amount*
Total patient care and special health service appropriation	$83,528
Operation of hospitals and clinics	74,854
Coast Guard	4,459
Federal employee health	450
Payments to Hawaii	1,200
Program direction	2,565
Total cost for operation of hospitals and clinics*	
Appropriated funds	74,854
Reimbursements (from DOD, grants, contracts)	12,479
Total	87,333
Average costs for services, PHS hospitals and clinics:	
Per diem costs for general hospitals	58.50
Depreciation—equipment and facilities	2.40
Total	60.90
Average cost per outpatient visit (hospitals)	12.31
Average cost per outpatient visit (clinics)	13.35
Total training costs fiscal year 1970	6,728,000
Total research costs fiscal year 1970	5,517,000

*Includes Carville.

PHS Hospitals

BALTIMORE, MD.

Operating Beds—238.

Workload (fiscal year 1970): ADPL, total—172 (72.3% occupancy rate); PHS beneficiaries—73; others—99; outpatient visits, total—94,609; PHS beneficiaries—21,597; others—73,012.

Budget fiscal year 1971—$8,532,454.

Per diem cost (fiscal year 1970)—$81.92 (average length of stay—15.3 days).

Outpatient visit cost (fiscal year 1970)—$12.31.

Personnel:	
Total	654
Commissioned officers, total	158
Physicians	100
Dentists	10
Pharmacists	13
Other	35
Civil service, total	496
Nursing	112
Dietary	53
Housekeeping	33
Laboratory	45
Radiology	26
Engineering and maintenance	38
Medical records	21
Other	168
Commissioned Officer Trainees (included in personnel figures above):	
Medical interns	10
Medical residents	33
Other	12
Total	55
Facility:	
Date of construction	1932
Size of property, acres	10.1
Number of buildings	9
Cost of modernization, million	$9.9

Potential community use, with moderate alterations—general hospital; extended care facility; community health center; extension to Johns Hopkins University.

BOSTON, MASS.

Operating beds—190.

Workload (fiscal year 1970): ADPL, total—126 (66.3 percent occupancy rate); PHS beneficiaries—77; others—49; outpatient visits, total—58,362; PHS beneficiaries—19,452; others—38,910.

Budget fiscal year 1971—$3,029,664.

Per diem cost (fiscal year 1970)—$60.00 (average length of stay 19.6 days).

Outpatient visit cost (fiscal year 1970)—$14.40.

Personnel:	
Total	304
Commissioned officers, total	60
Physicians	33
Dentists	9
Pharmacists	7
Other	11
Civil service, total	244
Nursing	62
Dietary	35
Housekeeping	19
Laboratory	14
Radiology	7
Engineering and maintenance	16
Medical records	12
Other	79

Commissioned officer trainees (included in personnel figures above):	
Medical interns	9
Medical residents	4
Other	6
Total	19
Facility:	
Date of construction	1940
Size of property, acres	12.6
Number of buildings	11
Cost of modernization, million	$8.7

Potential community use, with moderate alterations—extended care facility; community health center.

GALVESTON, TEX.

Operating Beds—160.
Workload (fiscal year 1970); ADPL, total—125 (78.1 percent occupancy rate); PHS beneficiaries—101; others—24; outpatient visits, total—45,277; PHS beneficiaries—22,707; others—22,570.
Budget fiscal year 1971—$3,350,792.
Per diem cost (fiscal year 1970)—$54.69 (average length of stay—16.1 days).
Outpatient visit cost (fiscal year 1970)—$11.82.

Personnel:	
Total	270
Commissioned officers, total	39
Physicians	24
Dentists	5
Pharmacists	4
Other	6
Civil service, total	231
Nursing	78
Dietary	33
Housekeeping	17
Laboratory	10
Radiology	5
Engineering and maintenance	21
Medical records	12
Other	55
Commissioned officer trainees (included in personnel figures above):	
Medical residents	2
Other	2
Total	4
Facility:	
Date of construction	1931
Size of property, acres	10.0
Number of buildings	10
Cost of modernization, million	$14.7

Potential community use, with moderate alterations—extended care facility; community health center; research facility for UTMB.

NEW ORLEANS, LA.

Operating beds—403.
Workload (fiscal year 1970): ADPL, total—307 (76.2 percent occupancy rate); PHS beneficiaries—207; others—100; outpatient visits, total—145,447; PHS beneficiaries—48,056; others—97,391.
Budget fiscal year 1971—$8,165,118.
Per diem cost (fiscal year 1970)—$47.53 (average length of stay—18.2 days).
Outpatient visit code (fiscal year 1970)—$8.48.

Personnel:	
Total	629
Commissioned officers, total	140
Physicians	92
Dentists	10
Pharmacists	15
Other	23
Civil Service, total	489
Nursing	147
Dietary	63
Housekeeping	37
Laboratory	37
Radiology	13
Engineering and maintenance	38
Medical records	32
Other	122
Commissioned officer trainees (included in personnel figures above):	
Medical interns	19
Medical residents	27
Other	10
Total	56
Facility:	
Date of construction	1932
Size of property, acres	17.2
Number of buildings	23
Cost of modernization, millions	$21.9

Potential community use, with extensive alternations—General Hospital; extended care facility; community health center.

NORFOLK, VA.

Operating beds—210.

Workload (fiscal year 1970): ADPL, total—142 (67.6 percent occupancy rate); PHS beneficiaries—71; others—71; outpatient visits, total—92,983; PHS beneficiaries—24,443; others—68,540.

Budget fiscal year 1971—$4,052,255.

Per diem cost (fiscal year 1970)—$61.04 (average length of stay—15.7 days).

Outpatient visit cost (fiscal year 1970)—$9.13.

Personnel:	
Total	332
Commissioned officers, total	42
Physicians	25
Dentists	6
Pharmacists	5
Other	6
Civil service, total	290
Nursing	101
Dietary	34
Housekeeping	22
Laboratory	16
Radiology	10
Engineering and maintenance	19
Medical records	16
Other	72

Commissioned officer trainees (included in personnel figures above):	
Medical interns	2
Other	3
Total	5
Facility:	
Date of construction; new wing added 1934	1922
Size of property (acres)	21.4
Number of buildings	11
Cost of modernization (million)	$13.5

Potential community use, with moderate alterations—General Hospital; extended care facility; community health center.

SAN FRANCISCO, CALIF.

Operating beds—366.

Workload (fiscal year 1970): ADPL, total—250 (68.3 percent occupancy rate); PHS beneficiaries—197; others—53; outpatient visits, total—118,574; PHS beneficiaries—78,591; others—39,983.

Budget fiscal year 1971—$9,956,737.

Per diem cost (fiscal year 1970)—$59.54 (average length of stay—17.4 days).

Outpatient visit cost (fiscal year 1970)—$15.41.

Personnel:	
Total	672
Commissioned officers, total	156
Physicians	109
Dentists	14
Pharmacists	8
Other	25
Civil service, total	516
Nursing	157
Dietary	59
Housekeeping	39
Laboratory	24
Radiology	20
Engineering and maintenance	37
Medical records	27
Other	153
Commissioned officer trainees (incinded in personnel figures above):	
Medical interns	20
Medical residents	28
Other	8
Total	56
Facility:	
Date of construction; alterations and additions 1953	1932
Size of property (acres)	36.4
Number of buildings	25
Cost of modernization (millions)	$12.6

Potential community use, with minimal alterations—General Hospital; extended care facility; community health center.

SEATTLE, WASH.

Operating beds—279.

Workload (fiscal year 1970): ADPL, total—180 (64.5 percent occupancy rate); PHS beneficiaries—75; others—105; outpatient visits, total—112,120; PHS beneficiaries—37,948; others—74,172.

Budget fiscal year 1971—$7,403,132.
Per diem cost (fiscal year 1970)—$72.21 (average length of stay—12.9 days).
Outpatient visit cost (fiscal year 1970)—$14.01.

Personnel:	
Total	520
Commissioned officers, total	113
Physicians	68
Dentists	16
Pharmacists	9
Other	20
Civil service, total	407
Nursing	116
Dietary	49
Housekeeping	30
Laboratory	35
Radiology	13
Engineering and maintenance	22
Medical records	17
Other	125
Commissioned officer trainees (included in personnel figures above):	
Medical residents	25
Other	12
Total	37
Facility:	
Date of construction (additions 1953)	1932
Size of property (acres)	9.9
Number of buildings	9
Cost of modernization (million)	$19.7

Potential community use—does not lend itself to profitable community use.

STATEN ISLAND, N.Y.

Operating beds—636.
Workload (fiscal year 1970): ADPL, total—420 (66.0 percent occupancy rate); PHS beneficiaries—268; others—152; outpatient visits, total—142,806; PHS beneficiaries—72,360; others—70,446.
Budget fiscal year 1971—$13,675,067.
Per diem cost (fiscal year 1970)—$60.46 (average length of stay: 19.5 days).
Outpatient visit cost (fiscal year 1970)—$14.82.

Personnel:	
Total	1,060
Commissioned officers, total	235
Physicians	162
Dentists	16
Pharmacists	14
Other	43
Civil service, total	825
Nursing	227
Dietary	126
Housekeeping	59
Laboratory	53
Radiology	38
Engineering and maintenance	74
Medical records	41
Other	207

Commissioned officer trainees (inclnded in personnel figures above):

Medical interns	30
Medical residents	68
Other	24
Total	122

Facility

Date of construction additions 1942 (some buildings in use were constructed in 1883)	1935
Size of property (acres)	24.1
Number of buildings	17
Cost of modernization (million)	$26.9

Potential community use, with extensive alterations—General Hospital; extended care facility; community health center.

P.H.S. Clinics

ANNETTE ISLAND, ALASKA

Workload (fiscal year 1970):	
Outpatient visits, total	2,079
PHS beneficiaries	772
Others	1,307
Budget fiscal year 1971	$17,600
Outpatient visit cost (fiscal year 1970)	8.47

Facility location—Indian health service:
Personnel—No staff assigned. Will only require administrative conversion to contract facility.

ATLANTA, GA.

Workload (fiscal year 1970):	
Ontpatient visit, total	14,854
PHS beneficiaries	3,240
Others	11,614
Bndget fiscal year 1971	$162,903

Facility location—Center for Disease Control.

Personnel:	
Total	12
Commissioned officers, total	2
Civil service, total	10

BALBOA HEIGHTS, C.Z.

Workload (fiscal year 1970):	
Outpatient Visits, total	6,866
PHS beneficiaries	6,822

Budget fiscal year 1971—included in New Orleans PHS Hospital budget.
Outpatient visit cost (fiscal year 1970)—$11.00.
Facility location—Panama Canal Co.
Personnel—no staff required. Will only require administrative conversion to contract facility.

BUFFALO, N.Y.

Workload (fiscal year 1970):	
Outpatient visits, total	9,273
PHS beneficiaries	3,502
Others	5,771

Budget fiscal year 1971	$129,190
Outpatient visit cost (fiscal year 1970)	13.76

Facility location—Post Office building (to be vacated prior to January 31, 1971).

Personnel:	
Total	8
Commissioned officers, total	1
Civil service, total	7

CHARLESTON, S.C.

Workload (fiscal year 1970):	
Outpatient visits, total	7,694
PHS beneficiaries	4,493
Others	3,201
Budget fiscal year 1971	$87,395
Outpatient visit cost (fiscal year 1970)	11.06

Facility location—Federal Building.

Personnel:	
Total	6
Commissioned officers, total	1
Civil service, total	5

CHARLOTTE AMALIE, V.I.

Workload (fiscal year 1970):	
Outpatient visits, total	288
PHS beneficiaries	65
Others	223
Budget fiscal year 1971	$3,700
Outpatient visit cost (fiscal year 1970)	14.34

Facility location—GSA contracted space.
Personnel: No staff assigned. Will only require administrative conversion to contract facility.

CHICAGO, ILL.

Workload (fiscal year 1970):	
Outpatient visits, total	53,474
PHS beneficiaries	3,629
Others	49,845
Budget fiscal year 1971	$887,695
Outpatient visit cost (fiscal year 1970)	14.16

Facility location—Previous USPHS Hospital building which has been donated to the city of Chicago Board of Education.

Personnel:	
Total	58
Commissioned officers, total	14
Civil service, total	44

CINCINNATI, OHIO

Workload (fiscal year 1970):	
Outpatient visits, total	15,347
PHS beneficiaries	2,001
Others	13,346
Budget fiscal year 1971	$172,601
Outpatient visit cost (fiscal year 1970)	10.69

Facility location—Post Office and Courthouse building.

Personnel:	
Total	12
Commissioned officers, total	2
Civil service, total	10

CLEVELAND, OHIO

Workload (fiscal year 1970):	
Outpatient visits, total	18,789
PHS beneficiaries	6,250
Others	12,539
Budget fiscal year 1971	$211,814
Outpatient visit cost (fiscal year 1970)	11.00

Facility location—New Post Office building.

Personnel:	
Total	15
Commissioned officers, total	5
Civil service, total	10

DETROIT, MICH.

Workload (fiscal year 1970):	
Outpatient visits, total	28,870
PHS beneficiaries	4,563
Others	24,307
Budget fiscal year 1971	$685,642
Outpatient visit cost (fiscal year 1970)	28.53

Facility location—Previous USPHS Hospital property which has been donated to State of Michigan.

Personnel:	
Total	38
Commissioned officers, total	8
Civil service, total	30

HONOLULU, HAWAII

Workload (fiscal year 1970):	
Outpatient visits, total	32,158
PHS beneficiaries	18,286
Others	13,872
Budget fiscal year 1971	$471,803
Outpatient visit cost (fiscal year 1970)	13.71

Facility location—Building and 1.5 acres acquired by PHS in 1963.

Personnel:	
Total	31
Commissioned officers, total	6
Civil service, total	25

HOUSTON, TEX.

Workload (fiscal year 1970):	
Outpatient visits, total	28,364
PHS beneficiaries	11,773
Others	16,591
Budget fiscal year 1971	$210,634
Outpatient visit cost (fiscal year 1970)	7.51

Facility location—Federal Building.

Personnel:	
Total	15
Commissioned officers, total	4
Civil service, total	11

JACKSONVILLE, FLA.

Workload (fiscal year 1970):	
Outpatient visits, total	13,252
PHS beneficiaries	8,780
Others	4,472
Budget fiscal year 1971	$162,142
Outpatient visit cost (fiscal year 1970)	9.58

Facility location—Federal Building.

Personnel:	
Total	9
Commissioned officers, total	3
Civil service, total	6

JUNEAU, ALASKA

Workload (fiscal year 1970):	
Outpatient visits, total	5,582
PHS beneficiaries	1,512
Others	4,070
Budget fiscal year 1971	$83,500
Outpatients visit cost (fiscal year 1970)	14.86

Facility location—St. Ann's Hospital.

Personnel: no staff assigned. Will only require administrative conversion to contract facility.

MEMPHIS, TENN.

Workload (fiscal year 1970):	
Outpatient visits, total	24,080
PHS beneficiaries	7,768
Others	16,312
Budget fiscal year 1971	$431,620
Outpatient visit cost (fiscal year 1970)	23.33

Facility location—rental.

Personnel:	
Total	28
Commissioned officers, total	5
Civil service, total	23

MIAMI, FLA.

Workload (fiscal year 1970):	
Outpatient visits, total	46,787
PHS beneficiaries	10,633
Others	36,154
Budget fiscal year 1971	$481,114
Outpatient visit cost (fiscal year 1970)	9.89

Facility location—Federal Building.

Personnel:	
Total	32
Commissioned officers, total	8
Civil service, total	24

MOBILE, ALA.

Workload (fiscal year 1970):	
Outpatient visits, total	23,170
PHS beneficiaries	16,746
Others	6,424
Budget fiscal year 1971	$295,969
Outpatient visit cost (fiscal year 1970)	$12.76

Facility location—Federal Building.

Personnel:	
Total	20
Commissioned officers, total	4
Civil service, total	16

NEW YORK, N.Y.

Workload (fiscal year 1970):	
Outpatient visits, total	115,857
PHS beneficiaries	56,765
Others	59,092
Budget fiscal year 1971	$1,223,524
Outpatient visit cost (fiscal year 1970)	$10.01

Facility location—Federal Office Building.

Personnel:	
Total	102
Commissioned officers, total	18
Civil service, total	84

PHILADELPHIA, PA.

Workload (fiscal year 1970):	
Outpatient visits, total	30,216
PHS beneficiaries	14,638
Others	15,578
Budget fiscal year 1971	$337,213
Outpatient visit cost (fiscal year 1970)	$11.30

Facility location—Building and 0.1 acres acquired by PHS in 1928.

Personnel:	
Total	24
Commissioned officers, total	5
Civil service, total	19

PITTSBURGH, PA.

Workload (fiscal year 1970):	
Outpatient visits, total	7,850
PHS beneficiaries	2,008
Others	5,842
Budget fiscal year 1971	$95,623
Outpatient visit cost (fiscal year 1970)	$14.25

Facility location—Post Office and Courthouse.

Personnel:	
Total	8
Commissioned officers, total	0
Civil service, total	8

PORT ARTHUR, TEX.

Workload (fiscal year 1970):	
Outpatient visits, total	6,863
PHS beneficiaries	4,852
Others	2,011
Budget fiscal year 1971	$71,705
Outpatient visit cost (fiscal year 1970)	9.49

Facility location—Federal Office Building.

Personnel:	
Total	3
Commissioned officers, total	0
Civil service, total	3

PORTLAND, MAINE

Workload (fiscal year 1970):	
Ontpatient visits, total	18,434
PHS beneficiaries	5,422
Others	13,012
Budget fiscal year 1971	$204,885
Outpatient visit cost (fiscal year 1970)	10.00

Facility location—6.9 acres acqnired by PHS in 1857; nnmber of bnildings—4 buildings.

Personnel:	
Total	14
Commissioned officers, total	4
Civil service, total	10

PORTLAND, OREG.

Workload (fiscal year 1970):	
Outpatient visits, total	19,214
PHS beneficiaries	5,395
Others	13,819
Bndget fiscal year 1971	$162,267
Ontpatient visit cost (fiscal year 1970)	9.58

Facility location—Courthouse.

Personnel:	
Total	12
Commissioned officers, total	4
Civil service, total	8

ST. LOUIS, MO.

Workload (fiscal year 1970):	
Outpatient visits, total	15,726
PHS bencficiaries	4,496
Others	11,230
Bndget fiscal year 1971	$206,862
Outpatient visit cost (fiscal year 1970)	12.17

Facility location—Federal Office Building.

Personnel:	
Total	14
Commissioned officers, total	4
Civil service, total	10

SAN DIEGO, CALIF.

Workload (fiscal year 1970):	
Outpatient visits, total	39,454
PHS beneficiaries	8,317
Others	31,137
Budget fiscal year 1971	$417,583
Outpatient visit cost (fiscal year 1970)	10.06

Facility location—rental.

Personnel:	
Total	26
Commissioned officers, total	5
Civil service, total	21

SAN JUAN, P.R.

Workload (fiscal year 1970):	
Outpatient visits, total	20,056
PHS beneficiaries	8,515
Others	11,541
Budget fiscal year 1971	$356,397
Outpatient visit cost (fiscal year 1970)	16.05

Facility location—7.9 acres acquired by PHS in 1940: number of buildings—12 buildings including 2 for NIH research and 1 for U.S. Coast Guard.

Personnel:	
Total	25
Commissioned officers, total	3
Civil service, total	22

SAN PEDRO, CALIF.

Workload (fiscal year 1970):	
Outpatient visits, total	79,411
PHS beneficiaries	48,834
Others	30,577
Budget fiscal year 1971	$829,003
Outpatient visit cost (fiscal year 1970)	10.85

Facility location—Post Office Building.

Personnel:	
Total	52
Commissioned officers, total	15
Civil service, total	37

SAVANNAH, GA.

Workload (fiscal year 1970):	
Outpatient visits, total	20,967
PHS beneficiaries	9,732
Others	11,235
Budget fiscal year 1971	$509,416
Outpatient visit cost (fiscal year 1970)	27.03

Facility location—building constructed in 1906 previously occupied by USPHS Hospital (0.6 acres).

Personnel:	
Total	37
Commissioned officers, total	5
Civil service, total	32

TAMPA FLA.

Workload (fiscal year 1970):	
Outpatient visits, total	32,046
PHS beneficiaries	10,690
Others	21,356
Budget fiscal year 1971	$383,733
Outpatient visit cost (fiscal year 1970)	11.68
Facility location—Federal Building.	
Personnel:	
Total	25
Commissioned officers, total	7
Civil service, total	18

WASHINGTON, D.C.

Workload fiscal year 1970):	
Outpatient visits, total	84,242
PHS beneficiaries	11,675
Others	72,567
Budget fiscal year 1971	$1,490,118
Outpatient visit cost (fiscal year 1970)	18.90
Facility location—HEW south building.	
Personnel:	
Total	112
Commissioned officers, total	17
Civil service, total	95

Personnel Management During Transition

Under the proposal to transfer Public Health Service facilities to community control, personnel currently employed at the hospitals would be assured of individual attention precluding, to the extent possible, abrupt interruption of their career plans. The Emergency Health Personnel Act of 1970 and other authorizations could permit individuals to retain their Federal status over a period of transition as employees of the community management agency. This approach should prove advantageous both to the employees and the community since it would provide for continuity of programs through the transition phase.

Future of the Commissioned Corps of the U.S. Public Health Service

The Secretary has appointed an eight member committee of distinguished citizens to examine the long range mission, purpose, and future of the Commissioned Corps of the U.S. Public Health Service. The Committee is under the Chairmanship of Dr. John A. Perkins, former Under Secretary of the Department of Health, Education, and Welfare in 1957–58.

The Committee has been asked to examine all facets of the Commissioned Corps, ranging from the use of PHS personnel in the ghettos and rural areas under the Emergency Health Personnel Act of 1970, to the role of PHS in providing medical care for seamen and Indians.

The findings of this Committee will be submitted to the Secretary within the next several months.

Cost of Replacement of Beds Currently Operated

The PHS system of 8 general hospitals currently has 2,482 operating beds. The cost to replace these beds will be $148,920,000, calculated at the current national average cost per bed of $60,000 for community hospitals with teaching

programs. This estimate does not include the Carville leprosarium. The present modernization plans do not anticipate replacing on a bed for bed basis the current operating capacity of the system as reflected in the above figures.

MODERNIZATION PROGRAM—PHS HOSPITALS

	Planning stage (system studies)	Planning funds expended or obligated	Recommendations		Projected costs for modernization (1971 costs) [1]
			Site	Type of improvement	
San Francisco	Completed	$230,587	Present	Modernization	$12,617,000
Galveston	do	205,604	UTMB	Replacement	14,686,000
New Orleans	do	386,865	Tulane	do	21,892,000
Seattle	1st phase	53,012	University of Washington.	do	19,671,000
Norfolk	do	46,621	Norfolk General Hospital.	do	13,452,000
Boston	do	29,000	Adjacent to Boston University.	do	8,683,000
Baltimore	Not started		To be determined	Modernization	9,919,000
Staten Island	do		do	do	26,923,000
Carville	A. & E. completed	[2] 428,955	Present	Replacement	13,608,000
Total		1,380,644			141,451,000

[1] Includes planning, A. & E., construction.
[2] A. & E. design to be completed this fiscal year. No formal systems study done.

Mr. ROGERS. Are there any other questions? Dr. Carter.

Mr. CARTER. I will yield to Mr. Nelsen.

Mr. NELSEN. When you closed the other hospitals in past years, did you run into turbulence?

Mr. CARDWELL. That is an understatement.

Dr. EGEBERG. There is a rumor that there was turbulence, local turbulence, and more general turbulence here.

Mr. NELSEN. Another question: The feeling that there will be a closing of the hospitals is based, in some people's minds, on the fact that there is no money for them in the budget. Is it possible that the budget is waiting for a determination on the part of HEW before they make a determination on the budget? Is that possible?

Dr. EGEBERG. Yes. I will answer this one for Mr. Cardwell, since he has answered it a couple of times, I think, in different ways.

There has been a clear understanding that we are going to have enough money to see to it that if keeping the hospital in our hands for a longer period of time or a shorter period of time is necessary to give the care that we are responsible for, it will be done.

Mr. NELSEN. I want to make this observation, too:

Certainly I would agree with our chairman that we want to exercise every care relative to these hospitals. I believe where a facility is not being used to its maximum and there is local community need for additional hospital beds we better look at this need in the interest of making the facility a better operation.

I would not want to be a party to saying we are going to close these hospitals right now, and I don't gather from the testimony that anybody is saying that. I think our committee should protect these hospitals until we determine which way to go.

I want to also point out that I ran an agency once and I got pummeled pretty good a few times, but some of the policies we set up then are today national policies in the rural electrification program, accepted as very much superior to some things that were being done

previously to that point. It may very well be you have some good ideas.

Thank you.

Mr. NELSEN. Thank you.

Mr. CARTER. I would like to have your admissions broken down as to age groups and further broken down as to the length of stay according to the age of the patient.

Dr. EGEBERG. Well, they are writing that down.

Dr. WILSON. I would not mislead you—well, if we have it, that is fine. If you had to dig it out, that is impossible.

Dr. EGEBERG. We do apparently have it and we will see that you get it, or the committee gets it.

(The following table was received for the record:)

AGE DISTRIBUTION OF PATIENTS DISCHARGED FROM PHS GENERAL HOSPITALS, FISCAL YEAR 1970

Age group	Number	Percent	Average length of stay
All ages	36,921	100.0	17.2
Under 15	2,149	5.8	5.9
15 to 24	6,812	18.4	12.9
25 to 34	4,161	11.3	14.0
35 to 44	5,855	15.9	16.5
45 to 54	7,348	19.9	19.7
55 to 64	6,603	17.9	22.1
65 and over	3,993	10.8	22.0

Note: Excludes newborns.

Mr. CARTER. By the way, I am sure most of you are familiar with an actress we had many years ago, Miss Sarah Bernhardt.

Dr. EGEBERG. I have seen her. I am old enough.

Mr. CARTER. Do you know if she was ever a patient at a Public Health Service hospital——

Dr. EGEBERG. That may have been when they took her leg off, I don't know.

Mr. CARTER. How did she obtain eligibility?

Dr. EGEBERG. Well, if it was an accident—I don't know. When I saw her she had a wooden leg and she did a very good job of acting even with it.

Mr. CARTER. You didn't answer the question.

Dr. EGEBERG. I wonder if that is part of the answer.

Have you a better one?

Dr. WILSON. No.

I don't know the circumstances, but I would assume that we do accept emergencies at any time.

Mr. CARTER. Would you check up on that?

Dr. WILSON. It would have been more of a pleasure earlier, but we will be glad to do it.

Mr. CARTER. I would like to have the basis for her admission. Of course, that has been quite a few years ago.

Dr. EGEBERG. Wouldn't you admit her to any hospital at that time, regardless of what the rules were?

Mr. CARTER. I am positive.

Dr. WILSON. One of my more serious minded staff members says that there have always been, of course, research endeavors of various kinds

that have brought special patients in. My own levity would lead me to believe that there might be intcresting research.

(The following information was received for the record:)

TREATMENT OF SARAH BERNHARDT IN A PHS HOSPITAL

We have been unable to locate information concerning treatment rendered to Sarah Bernhardt at a Public Health Service facility. On February 22, 1915 she had a leg amputated by a Dr. Denuce in Bordeaux, France. To our knowledge, this episode had no relationship to the Public Health Service hospitals.

Mr. ROGERS. Mr. Satterfield.

Mr. SATTERFIELD. I just have one question, a point which came up. I think a statement was made that you intended to rely heavily on the Veterans' Administration hospitals. Did I understand that correctly?

Dr. EGEBERG. No. That was one of the sources that we anticipated. At the present time their number of available beds has been reduced to a degree that makes them not a very good source to look to.

Mr. SATTERFIELD. I knew it was a fact that merchant marine seamen would be in about a fourth priority insofar as getting into V.A. hospitals is concerned. I didn't know to what extent you intended to rely on V.A. hospitals and whether or not we might expect some request for legislation in this area.

Mr. CARDWELL. I think I am the one who made the comment that led you to that question. I said that as the budget now stands, it does assume significant reliance on the use of cross-servicing agreements with the Vcterans' Administration for contract care. We will still be exploring with Veterans' Administration opportunities to extend and to enlarge the services that they have been providing us with for several years.

Mr. SATTERFIELD. But merchant marine and the people who are your beneficiaries are way down the list on priorities.

Mr. CARDWELL. Yes. But it still works out that they receive care.

Dr. EGEBERG. If that was to be an arrangement obviously they would have to have a priority equal to that of the other people admitted to the hospital.

Mr. SATTERFIELD. But that would require legislation. I wondered whether we would be receiving such a proposal.

Mr. CARDWELL. We have no proposal of that kind.

Dr. WILSON. In the discussion before our assumption has been that there were beds on an as-available basis. The priority to which you allude is a priority for admission, not a priority on care once they are in the hospital.

Mr. SATTERFIELD. But if they are not in the hospital they will not receive the care.

Dr. WILSON. That is right. We have never assumed that we would have anything other than an as-available in the planning, with the reduction in beds contemplated by the VA budget. We might have thought that was a viable thought at one time but it probably is not a large resource at this time.

Mr. ROGERS. Mr. Roy.

Mr. ROY. I am new and probably innocent, but we started out on chronology and we never got very far. My question is, Which came first, the decision to decrease the budget or the proposition that we would transfer these hospitals to local groups?

Dr. EGEBERG. Our investigation of the whole problem with the prime purpose of doing a better job definitely came first. Within that context came our discussion of the question of trying to transfer if that seemed feasible. Then, as Mr. Cardwell said, as it evolved further—and at one time we felt there were four hospitals that we would like to transfer to another agency, that is, to a local agency, a medical school or otherwise—then it got into involvement with the Bureau of Management and Budget.

Mr. CARDWELL. Actually, the real chronology of this goes back many, many years. The basic question about whether this is a viable arrangement has been asked many, many times by both Democratic and Republican administrations. The executive branch approach to it in the past has always been to decide at the time they file a given budget that they would close the hospitals then and there in that year, and the Congress has always said "No, you can't do that." Our position from the very beginning in this particular review of it was that we should not make that kind of proposal to the Congress. Yet when the word got out that we were again reviewing this basic question—the assumption was immediately made that we were going to attempt the same approach that Congress has consistently blocked.

Mr. ROY. Thank you.

Mr. ROGERS. I noticed in the hearings before a subcommittee of the Committee on Appropriations in the 91st Congress, second session, they talked about letting community health activities help supplement the filling of the hospitals. This is HEW speaking. In fact, I think it was out of your office. Also, the issues of the hospital were also mentioned.

This is Dr. English, who was your predecessor, speaking in this past year. He said:

> It would be my judgment that this study—

Talking about the hospitals—

> would take into account not only the potential of these hospitals to serve the present beneficiaries, but the tremendous potential which they have for research and development. In terms of the $61 billion enterprise which health and mental health services represent in the United States, a tremendous share of which is Federal, we feel that the Federal Government has the responsibility to do some experimentation in an attempt to try to serve these needs. Dr. Egeberg has testified to his judgment before other committees of the Congress that it is conceivable that these hospitals could be tremendously important in that Federal effort, and I think the study that is being done now will certainly take that into account.

And I presume that it will.

Dr. EGEBERG. Yes, it will.

Mr. ROGERS. How do you plan to do your research and innovation in-house if you don't have any hospitals?

Dr. WILSON. I think there are two answers, Mr. Chairman. Of course, we have the National Center for Health Services R. & D. with whom we work closely, for instance, in the Indian Health Service, which is a much more complete service from a health care point of view than the PHS hospitals. It goes all the way into community support of the health services and provides basically total care.

The other thing, I think, that we feel will assist us in the matter of research is, our growing participation in neighborhood health services.

As you know, there were 14, I believe, of the OEO Centers that were transferred to us for which we have a very basic responsibility. We think we have a heavy enough responsibility in relationship to those because of the support that comes from HEW that we can do a great deal of delivery research under those too. We have hospitals in the Indian Health Service and good neighborhood contact in the neighborhood comprehensive health centers.

Mr. ROGERS. But you don't have any hospitals other than the Indian hospitals. How many Indian hospitals do you have?

Dr. EGEBERG. We do have the Carville Leprosy Sanitarium which of course, is a very special hospital.

Mr. ROGERS. I don't think that would serve too well.

Dr. EGEBERG. Not for general medical and surgical. And then we have Lexington.

Mr. ROGERS. That is narcotics.

Dr. EGEBERG. Yes. And HEW operates the Clinical Research Center on the NIH campus which is a very large and very sophisticated kind of hospital.

Mr. ROGERS. But it is not for delivery of services. That is research.

Dr. EGEBERG. That is right.

Mr. ROGERS. Of course.

Dr. EGEBERG. You were mentioning hospitals.

Mr. ROGERS. I am saying where you could carry out this type of research, delivery of services, to get down and see what a community needs, how it ought to be done. You ought to be innovating, showing the way.

Dr. EGEBERG. We assume that the majority of the care in the country is actually going on in the private sector and that our work through the National Center for Health Services R. & D. in conjunction with the private sector gives us a more pertinent laboratory than I think something we would operate directly. I would not in any way deny that there are some quick advantages in operating a hospital, but I am not at all sure it is worth the price we may have to pay to do it.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. I want to compliment the gentlemen. I think they are being exceptionally innovative.

You said here today that you would transform these clinics, some of them, and perhaps the hospitals, to health maintenance organizations. That is very fine.

Mr. ROGERS. The committee will meet again Tuesday at 10 a.m. in room 2325, which is down the hall.

Also I would like to put into the record the overall summary and individual hospital summary site visits, January 8 to 22, 1971, which gives the team onsite information.

(The summary referred to follows:)

Overall Summary and Individual Hospital Summaries—Site Visits (January 18–22, 1971)

OVERALL SUMMARY OF SITE VISITS TO THE EIGHT PHS HOSPITALS

During the week of January 18, 1971, teams representing the Department of HEW visited the 8 cities where PHS hospitals are located to discuss with community leaders, beneficiary groups, and employees the impact of possible changes in the medical care programs of these facilities. These visits were a follow-up to the Department's testimony before the House Merchant Marine and Fisheries Committee that before a decision was made regarding the future of PHS facilities the affected communities would be consulted.

Although each PHS hospital is unique in the role it plays within the community, the information obtained from the involved communities had certain common themes.

1. Each community considers the PHS hospital an important and integral part of the local health care system.

2. The communities question the inference that closure of PHS hospitals will result in Federal savings.

3. The quality of care provided at the hospitals is generally considered excellent. The communities state that services provided at the hospitals are efficient; they acknowledge that in some locations they may not be operating at optimum efficiency due to an outmoded physical plant and restrictions on eligibility of care for community residents.

4. Quantitatively, the ability of the local medical care resources to absorb patient loads varies from location to location, and the range and quality of services presently being provided at the PHS hospitals may be difficult to duplicate. Discontinuing dental services will be a major problem for PHS beneficiaries.

5. Federal beneficiaries are not convinced that alternative arrangements for medical care will prove to be as acceptable as the services they now receive at PHS facilities.

6. Loss of a PHS facility with its full-time medical staff, will have an effect on health manpower development programs within the communities.

7. In several locations the local PHS hospital offers specialty services which are not currently available in sufficient quantity in the community and are utilized by community residents.

8. In the larger hospitals significant investment has been made in special research facilities which will be difficult and expensive to relocate.

For information purposes, the team members have prepared a comparative rating system for the hospitals. This should be viewed as a roughly quantified comparison of the impact that discontinuing the local PHS hospital programs would have on the affected communities. Since the rating systems is comparing one PHS hospital against the remaining 7, it has no value in an absolute sense, i.e., the fact that the Boston hospital scores lower than the others should not be interpreted as meaning the discontinuation of programs at this hospital would have little or no effect on the Boston community, only that the effects on the community would be less, in the judgment of the raters, than discontinuing, for example, the Staten Island hospital programs. The following factors were rated:

(1) Ability of other Federal and non-Federal facilities to absorb PHS patient care workloads.

(2) Effect on community educational and training programs.

(3) Ability to transfer researeh programs to other community facilities.

(4) Impact of discontinuing health services to nonbeneficiary community populations.

(5) Ability of the community to employ HEW personnel.

(6) Impact on the local economy.

Though these various factors have differing relative values for this comparison, each factor was considered to have the same weight. Applying different weights to the factors will change somewhat the scores for each hospital.

It was pointed out that regardless of the merits for or against continued operation of PHS hospitals, the communities will require an opportunity to properly assess the total impact of proposed PHS program changes on community resources and to work out alternative arrangements for services being provided at the PHS hospitals.

Impact on—	Boston	Staten Island	Baltimore	Norfolk	New Orleans	Galveston	Seattle	San Francisco
Alternative medical care resources in community:								
Military:								
Beds	4	4	3	3	4	4	3	2
Outpatient	3	4	3	4	4	4	4	3
Non-Federal:								
Beds	2	4	3	4	4	3	1	2
Outpatient	2	4	4	4	4	4	2	2
Training:								
Intramural	1	4	3	1	3	1	4	4
Affiliated	2	4	3	2	4	2	4	3
Health services to community:								
General medical	1	3	3	1	3	1	2	2
Specialty	2	4	3	2	3	1	3	4
Research:								
Clinical	2	4	4	1	3	1	4	4
Health services	1	1	4	1	3	1	1	1
Economy	2	4	2	2	2	3	4	2
Employment	2	4	3	3	3	4	4	4
Total	24	44	38	28	40	29	36	32

Note: For rating purposes, a relative scale of 0–4 was used: 0—No effect on community; 1—Relative minimal effect; 2—Moderate effect; 3—Major effect; 4—Major effect.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, BALTIMORE, MARYLAND

Operating Beds, 238
Workload (FY 1970):
- ADPL, Total, 172 (72.3% occupancy rate)
  - PHS Beneficiaries, 73
  - Others, 99
- Outpatient Visits, Total, 94,609
  - PHS Beneficiaries, 21,597
  - Others, 73,012

Budget FY 1971, $8,532,454
Per Diem Cost (FY 1970), $81.92 (Average Length of Stay, 15.3 days)
Outpatient Visit Cost (FY 1970), $12.31
Personnel:
- Total, 654
  - Commissioned Officers, Total, 158
    - Physicians, 100
    - Dentists, 10
    - Pharmacists, 13
    - Other, 35
  - Civil Service, Total, 496
    - Nursing, 112
    - Dietary, 53
    - Housekeeping, 33
    - Laboratory, 45
    - Radiology, 26
    - Engineering and Maintenance, 38
    - Medical Records, 21
    - Other, 168

Commissioned Officer Trainees (included in personnel figures above):
- Medical Interns, 10
- Medical Residents, 33
- Other, 12
- Total, 55

Facility:
- Date of Construction, 1932
- Size of Property, 10.1 acres
- Number of Buildings, 9
- Cost of Modernization, $9.9 million
- Potential community use, with moderate alterations—
  - General Hospital,
  - Extended Care Facility,
  - Community Health Center,
  - Extension to Johns Hopkins University

SUMMARY OF SITE VISIT TO PHS HOSPITAL BALTIMORE, JANUARY 18–19, 1971

I. PATIENT CARE

A. Discussions were held with key health leaders and others concerned from the Community to determine the capacity of local health resources to absorb patient workloads should services provided by Baltimore PHS hospital be discontinued.

1. *Inpatient resources.*—The current occupancy rate in Baltimore for non-Federal medical-surgical beds is 86.0% with waiting lists for elective admissions. With the exception of Maryland General, the hospital representatives stated that medical-surgical bed shortages are critical. Maryland General stated that, at times, they could accommodate up to 20–30 medical-surgical inpatients. Contract costs for hospitalization would range from $95–$112.50 per day exclusive of physician fees.

2. *Outpatient resources.*—Between 1.5 and 2 million visits per year are experienced by outpatient clinics in the city of Baltimore. The 100,000 visits at the Baltimore PHS Hospital constitute 5–10% of this total. Average cost per visit in the Baltimore area ranges from $17–$39.75.

3. *Dental Care.*—The PHS hospital has the second largest dental clinic in Baltimore, and the community would have a problem absorbing this load.

4. *Other Considerations.*—Community leaders felt much more time is necessary to fully evaluate the effect closure action would have on the community and the beneficiaries.

5. *Impact on Other Federal Facilities.*—Fort Meade (152 beds) and Annapolis (100 beds) are the alternative military hospitals for the 80,000 Department of Defense uniformed members, retirees, and dependents in the area. In addition, there is a dispensary at Fort Holabird but the future of this facility is in question. The PHS hospital is used as a primary source of care and as a referral center for many DOD beneficiaries (over 60,000 outpatient visits and over 1,100 hospital admissions in FY 1970). The military representatives present could not officially comment on the adequacy of their facilities to absorb the above workloads.

The two VA hospitals at Baltimore operate a total of 668 beds. The VA representatives had no comment on the ability of these facilities to absorb the 73 average daily patient load or the 22,000 outpatient visits by primary beneficiaries presently experienced at the PHS hospital.

B. Beneficiary reactions to possible alternatives

1. *American seamen.*—Seamen expressed opposition to alternative arrangements for medical care for the following reasons: (a) the PHS hospitals are their primary source of care, and the personnel are familiar with the special needs of seamen; (b) VA facilities would treat them as secondary beneficiaries and they question the quality of care in VA hospitals; (c) because of the transient nature of their occupation, seamen cannot establish firm doctor-patient relationships in the private sector. They can always go to a PHS hospital for care but cannot always find other resources.

2. *Uniformed Service Personnel.*—Dependents and Retirees indicated that other military facilities are crowded and inconvenient and do not have the range of services available at the PHS hospital. They also stated that the CHAMPUS program is not satisfactory because (a) the deductibles create a financial hardship, especially for the families of lower grade enlisted personnel; and (b) most private doctors do not wish to participate in CHAMPUS and the patient must fill out complicated forms for reimbursement.

II. IMPACT ON TRAINING AND EDUCATIONAL INSTITUTIONS

A. Training affiliations

1. *Medical Schools.*—The University of Maryland presently uses the PHS hospital as a clinical training resource for sophomore medical students, and plans to expand its classes to 200 over the next few years. John Hopkins presently nses the PHS hospital for medical student training in Ophthalmology, and have plans for expanion of classes from 115 to 150. Both schools have affiliations with PHS for postgraduate training and many PHS physicians have faculty appointments at the schools.

2. *School of Hygiene and Public Health.*—The Johns Hopkins University and the PHS hospital have an affiliated Preventive Medicine program in which

physicians are dually trained in operational research and preventive medicine to prepare them for research in the delivery of medical care.

3. *University of Maryland School of Pharmacy.*—The hospital is utilized for clinical clerkships, and an affiliated graduate level program has been initiated to commence July 1971.

4. *Physical Therapy Training.*—The University of Pennsylvania, the University of Maryland and New York University have training affiliations with the Physical Therapy Department.

5. *Nurse Training.*—Several schools of nursing utilize the PHS hospital for clinical training.

B. Intra-mural training

10 Medical Interns, 33 Medical Residents, 5 Dental Interns and Residents, 3 Pharmacy Residents, 11 Medical Record Librarian Students, 8 Medical Technology Students, 60 Dept. of Labor program for unemployed and Neighborhood Youth Corps.

Other Affiliations.—The University of Maryland Dental School, Loyola University, the Baltimore Department of Health, the Bryman School for medical assistants, the Community College of Baltimore, and other local institutions utilize the facilities at the PHS hospital for clinical training in several health categories.

III. RESEARCH

The hospital conducts both clinical and health services research.

A. Clinical research is chiefly in the fields of cardiovascular disease and cancer. These programs are largely funded, either directly or through grants, by the National Institutes of Health. The National Cancer Institute funds the Cancer Research Center at the hospital, and currently operates 35 beds.

The National Heart and Lung Institute supports three long range studies in the prevention of cardiovascular disease. These programs have been underway for several years.

B. The Baltimore hospital has a center for research in the organization and delivery of health services. Most of the studies are in the field of automation and operational research, a good part of which are conducted in collaboration with Johns Hopkins University.

IV. COMMUNITY PROGRAMS

A. Specialty services available to the community

1. *Cardiac catheterization.*—The PHS hospital is one of two institutions in Baltimore with the necessary staff and equipment to perform specialized procedures involving cardiac catheterization.

2. *Cancer treatment.*—The research center has highly trained staff and special equipment to perform special diagnostic and treatment procedures for several forms of cancer.

3. *Health Evaluation Center.*—The hospital has a second generation multiphasic screening system.

4. *Lipid Laboratory.*—For the study of blood lipids.

B. Community cooperative programs

1. *Training.*—The staff of the hospital is involved in health education programs within the Baltimore public schools.

2. *Patient Care.*—The staff of the hospital assists the city health department in the examination of school children, provides medical examinations for enrollees in Department of Labor programs for the unemployed, and serves as a resources for emergency hospitalization of community residents.

The hospital has worked with several medically deprived communities in planning for the establishment of a cooperative comprehensive medical care program.

V. EMPLOYMENT

There were three primary issues raised. One was the impact of the rumored closing of the Fort Holabird installation and a reduction in force at Fort Detrick. This would increase the difficulty of placing PHS employees. Mr. Burns of the Civil Service Commission in Baltimore reported that "the Displaced Employee Program has a number one priority in the Baltimore area." He noted that they have had most success in placing the clerical occupations, followed by blue

collar manual laboring, and that specialized technicians have been more difficult to place.

A second major impact concerned those persons serving medical residencies in the PHS hospital. Many have contacted other training programs and have been unable to find satisfactory positions. This is especially true in Ophthalmology and Otolaryngology.

The third critical aspect is that reported by Mr. Ben Hinden, National Office Representative of NFFE. He reports that Baltimore has a large lower income level population and that any closure would hit this group of employees the hardest.

VI. ECONOMIC IMPACT

Although discontinuing the operation of the hospital would deprive the community of an $8 million payroll, this did not stimulate much discussion among the community representatives.

VII. ALTERNATIVE USES OF FACILITY

The community representatives strongly supported the continued operation of the hospital as a Federal program with an expanded role in community health activities. It was stated that the organized services available at the hospital represent a more valuable asset than the buildings themselves; more time would be required to explore alternative uses of the facility; and that financing would have to be arranged.

VIII. MISCELLANEOUS

The Baltimore PHS Hospital has long provided examination and treatment services to Federal agencies (50,000 employees) in the area. In some instances the beneficiaries are Federal employees; in others they are prisoners, addicts, defendants, etc. The Bureau of Employees' Compensation estimates that closure of the Baltimore PHS Hospital would result in an additional cost to the Government of $0.5 million.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, BOSTON, MASS.

Operating Beds, 190.
Workload (FY 1970):
- ADPL, Total, 126 (66.3% occupancy rate).
  - PHS Beneficiaries, 77.
  - Others, 49.
- Outpatient Visits, Total, 58,362.
  - PH Beneficiaries, 19,452.
  - Others, 38,910.

Budget, FY 1971, $3,929,664.
Per Diem Cost (FY 1970), $60.00 (Average Length of Stay, 19.6 days).
Outpatient Visit Cost (FY 1970), $14.40.
Personnel:
- Total: 304.
  - Commissioned Officers, Total, 60.
    - Physicians, 33.
    - Dentists, 9.
    - Pharmacists, 7.
    - Other, 11.
  - Civil Service. Total, 244.
    - Nursing, 78.
    - Dietary, 35.
    - Housekeeping, 19.
    - Laboratory, 14.
    - Radiology, 7.
    - Engineering and Maintenance, 16.
    - Medical Records, 12.
    - Other, 63.

Commissioned Officer Trainees (included in personnel figures above):
- Medical Interns, 9
- Medical Residents, 4
- Other, 6
- Total, 19

Facility:
Date of Construction, 1940
Size of Property, 12.6 acres
Number of Buildings, 11
Cost of Modernization, $8.7 million
Potential community use (with moderate alterations)
Extended Care Facility
Community Health Center

SUMMARY OF SITE VISIT TO BOSTON PUBLIC HEALTH SERVICE HOSPITAL, JANUARY 18–19, 1971

This 190 bed facility is currently operating with an average daily patient load of 126 and provides nearly 60,000 out-patient visits yearly to its range of beneficiaries. All groups—beneficiary, unions, community leaders, health providers, educational institutions and governmental units uniformly and vigorously oppose the closure of the hospital.

PATIENT CARE

The Boston Hospital serves as a regional center for referral of Merchant Marine and fishermen as well as Coast Guard active duty and dependents from an area ranging from Cape Cod to Maine. Representatives of the Seamen and Fisherman's Unions stated that they are not accepted for care within their communities, that the doctors were overburdened with patients and the hospitals crowded to overflowing. They were not interested in obtaining care at VA facilities where they felt care was poor and where they would be third class citizens. Severe retrenchment in the military's in-patient and out-patient capacity has taken place over the last several years and the two remaining principal installations, Ft. Devens, currently a 500 bed facility will be reduced to approximately 116 beds after July 1, 1971, and the Chelsea Naval Hospital, a 500 bed facility may be phased out at the end of this fiscal year as well. The medical staff at Otis Air Field has been reduced by ⅔ and may be further reduced as part of an overall military reduction. The concomitant impact of these pending reductions in in-patient and out-patient services, coupled with the potential PHS action, would reduce direct care for the active duty and dependent Coast Guard personnel stationed in the area, which number some 15,000, as well as for retired military personnel in the area. Use of the OCHAMPUS program for the provision of services to dependents and retirees was generally felt to be a potential financial and physical hardship on retired and enlisted personnel and would be more costly to the various services than the current arrangements. The only military installation which would not appear to be contemplating some major reduction in capacity is the Dispensary located in Hamscom Field. This out-patient facility is currently operating near capacity serving a total population of roughly 16,000 individuals. The PHS Hospital provides Hamscom with specialty consultation services and conducts specialty clinics at their facility on a weekly basis.

Representatives of the Boston Health Services Community as well as the consumer and community groups pointed out that as a world medical center, Boston had 5,590 medical/surgical beds running at an occupancy rate of 85%, but that a significant number of people hospitalized were from outside the Boston area. Furthermore, average occupancy rates are brought down by lower week-end utilization and the drops during non-peak workload times.

Concerns were voiced about the economics of seeking alternative community based care for PHS beneficiaries in view of the present medical rates established by the Rate Setting Commission in the state of Massachusetts, i.e. the Brigham Hospital $130 per day, Massachusetts General Hospital $108 per day, and the Suburban Boston Metropolitan Hospitals $70 per day. It was further pointed out that these rates did not reflect professional fees nor many of the other hospital charges that could be expected. Similarly, although large numbers of ambulatory care visits are provided by the hospital systems in the greater Boston area, it was stated that they are running at capacity, waiting periods are long, and the availability of private physicians to provide ambulatory care is becoming increasingly difficult. Similar predictions were made with respect to the availability of dental health services. In view of the large number of hospital beds and physicians at least one community provider stated that the present workload of the PHS Hospital could be absorbed in the greater metropolitan Boston area and in those outlying communities where beneficiaries reside. Others felt that severe personal and financial stresses could be expected to impact on military dependents and retired personnel.

HEALTH SERVICES TO THE COMMUNITY

The College Mental Health Center program is a consortium of psychiatrists and support personnel who have entered into an agreement with a large number of universities and colleges in the greater Boston area, serving 67,000 students, to provide ambulatory and in-patient psychiatric services to their student bodies. The Brighton Hospital provides the physical plan to house this in-patient service and the core supportive and laboratory services that are required. In addition, emergency medical backup to meet the physical requirements of the hospitalized students are provided by PHS staff. The capacity of the unit is 20 beds and the current census of 10 patients is currently being expanded to that level. The Directors of the College Mental Health Center program indicated that in the foreseeable future they could visualize a 40 bed institution and there is sufficient space to expand to that level of effort. The much lower per diem costs associated with this particular partnership relationship with the Public Health Service make it possible for them to provide service at far less cost to the universities and they anticipate that their average length of stay for hospitalized students will range in the area of two weeks rather than the currently experienced three weeks in other private institutions, an additional savings.

One other major extension into the community is associated with a hospital based family planning clinic which is funded by OEO through the Health Department to the Alliance for Boston Community Development (ABCD). It is the only organized family planning effort serving 60,000 people who live in Allston, Brighton. The current patient load is ranging between 75 and 100 patients per week.

TRAINING AND EDUCATION

The Boston PHS Hospital is an affiliate of the Boston University School of Medicine, and participates in the clinical training of approximately 30 second, third, and fourth year medical students. Boston University has eight other such hospital affiliations in the area; it could, if necessary place these students in other than the PHS Hospital. In response to medical manpower needs, Boston University plans to increase the number of students in its medical class from the current 96 to 120 and up to 200 in the near future. To do this, it will need to expand its hospital affiliations and not cut back. Affiliations with Boston University and with Northeastern University for the training of physical therapists involve about 11 students a year for that portion of their curriculum which requires exposure to acute medical and surgical rehabilitation problems. In addition, Boston University is considering the possibility of starting a physical therapy assistant program and similar clinical affiliations will be needed for this effort. Additional affiliations in the allied health field include dental assistant clinical training with the Boston Trade School for Girls involving about 15 students, and the use of PHS Hospital staff for teaching purposes; medical laboratory assistants with the Blue Hills Regional Technical School involving four students; medical record technicians from the Ringe Technical School consisting of four students; and 70 third and fourth year students from the Massachusetts College of Optometry who participate in clinical sessions supervised by the PHS Ophthalmologist.

There are four medical residents and nine medical interns currently in training at the PHS Hospital.

RESEARCH ACTIVITIES

For the past ten years, the U.S. Public Health Service Hospital, Boston, Massachusetts, has participated in the Public Health Service Cooperative Studies on Hypertension, Cooperative Studies of Pyelonephritis and Renal Function and Bacteriuria and Cooperative Studies in Cancer Chemotherapy as a member of the Eastern Cooperative Oncology Group and the Regional Medical Program for Cancer.

ECONOMIC IMPACT AND EMPLOYEE PLACEMENT

At the present time the State of Massachusetts is facing its worst unemployment crisis since 1958. More than 156,000 people are out of work. About 1,500 persons per week are exhausting their maximum unemployment, and some may be forced to go on welfare. The situation in the Boston area is a little better than the rest of the State. In Boston, unemployment is running at 4.8 percent (71,200 unemployed) whereas statewide the figure is about 6.0 percent.

In the Boston area, the need for professional medical and paramedical personnel is quite great, with current published opportunities for nurses, X-ray technicians, and physicial therapists. Employment possibilities in the areas of dietary, housekeeping, engineering and maintenance, and various administrative categories is much more restricted. These categories account for a total of 133 employees, about 45% of the 300 hospital employment. Approximately 60 people would be eligible for retirement, and about half of these would retire on a reduced annuity.

POTENTIAL USES OF FACILITY

Representatives of the Model Cities program, the Boston Health Department, the "B" Health Planning Agency, the Neighborhood Health Center program, the State Health Department, and other community groups indicated more detailed planning would be required prior to making a firm recommendation though there are a number of possibilities to be considered such as:

1. Extended care facility;
2. Community health center;
3. Intermediary care facility (use as short-term stay facility between primary care facility in the community and university medical center);
4. Drug addiction treatment facility; and
5. Mental health center.

Funding appeared to be the major problem in taking over and maintaining of the facility, for whatever use.

The general consensus was that it would be best for the USPHS Hospital to remain open, to continue to provide care for beneficiaries, and to expand and improve its role in the medical and health needs of the community.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, GALVESTON, TEX.

Operating Beds, 160
Workload (FY 1970):
- ADPL, Total, 125 (78.1% occupancy rate)
  - PHS Beneficiaries, 101
  - Others, 24
- Outpatient Visits, Total, 45,277
  - PHS Beneficiaries, 22,707
  - Others, 22,570

Budget FY 1971, $3,350,792
Per Diem Cost (FY 1970), $54.69 (Average Length of Stay, 16.1 days)
Outpatient Visit Cost (FY 1970), $11.82
Personnel:
- Total, 270
  - Commissioned Officers, Total, 39
    - Physicians, 24
    - Dentists, 5
    - Pharmacists, 4
    - Other, 6
  - Civil Service, Total, 231
    - Nursing, 78
    - Dietary, 33
    - Housekeeping, 17
    - Laboratory, 10
    - Radiology, 5
    - Engineering and Maintenance, 21
    - Medical Records, 12
    - Other, 55

Commissioned Officer Trainees (included in personnel figures above):
- Medical Residents, 2
- Other, 2
- Total, 4

Facility:
- Date of Construction, 1931
- Size of Property, 10.0 acres
- Number of Buildings, 10
- Cost of Modernization, $14.7 million
- Potential community use, with moderate alterations
  - Extended Care Facility
  - Community Health Center
  - Research Facility for UTMB

Summary of Site Visit to PHS Hospital Galveston, January 21–22, 1971

CONSENSUS

The Public Health Service Hospital in Galveston is looked upon by the University of Texas Medical Branch, the city administration, and the people of the community as an essential resource not only as relates to the delivery of inpatient and outpatient medical care but also to health training and community action programs. Concern was exhibited at all levels regarding the effect on the community's economy and employment opportunities.

PATIENT CARE

The current PHS Hospital's annual patient load is 20,125 hospital days and 45,277 medical and dental outpatient visits. Community authorities point out that there is no other Federal hospital facility (DOD or VA) within reasonable distance. The nearest military facility is over 200 miles away. The nearest Veterans hospital is 65 miles away and reports an occupancy rate of 95%. It is their opinion that the uniformed services' and dependents' load as well as PHS primary beneficiaries would have to be absorbed by the Galveston medical and hospital resources. DOD active duty hospital admissions in 1970 were 289 or an average daily patient load of 9 and 6,415 outpatient visits. The dependents admissions number 213 (8 ADPL) and 15,078 outpatient visits.

The Galveston community hospitals are St. Mary's with 245 beds and an occupancy rate of 90% and Galveston County Memorial with 315 beds and a 75% occupancy rate. From statements received, neither offers significant possibilities to absorb the Public Health Service load, either inpatient or outpatient. The University of Texas Medical Branch Hospital with 1,061 beds and a 78% occupancy rate indicates that it could not adjust its inpatient and outpatient programs to accommodate PHS patients in the immediate future. UTMB leaders point out the need for preplanning, construction of added facilities and a commitment of financial support in order to assimilate the PHS load.

Currently there are 78 physicians in private practice in the Galveston area of which only 16 are listed as general practitioners and 19 not classified; thus, the majority of private physicians are specialty oriented. Difficulties in obtaining private medical care were cited and it is evident that an attempt to absorb the Public Health Service load would complicate the problems of the general public in obtaining medical care.

It was also indicated that private dental care would be difficult or impossible to obtain in the Galveston area as demonstrated by the reported waiting lists for appointments. The University Hospital does not have facilities or staff to accommodate the Public Health Service dental visit load of 7,432 visits and dental care provided would be limited to emergencies.

Beneficiaries expressed their satisfaction with the high quality of medical care received at the Public Health Service Hospital, which was substantiated by consultants repeatedly. Beneficiaries also evidenced concern as to the availability of private medical care.

HEALTH SERVICES TO THE COMMUNITY

At present the hospital is providing physical examinations to disadvantaged boys prior to camp attendance and providing the Neighborhood Youth Corps with training, and counseling for enrollees in the NYC two-year program for high school dropouts.

The city of Galveston looks to the hospital for advice and guidance in the general field of public health, particularly at present when the city has no public health officer. The entire area depends on the hospital for help during disasters such as hurricanes and epidemics.

In addition to the above are two planned programs. Under one of these the hospital would become the Galveston Island Facility for the Galveston County Coordinated Community Clinics (4 C's). The 4 C's program is funded by HEW and is designed to promote better health care for the medically deprived citizens of Galveston County. The hospital's location, facilities, and resources are considered ideal for utilization in the program.

A second proposed program would locate the medical portion of the Man-in-the-Sea program at the hospital. Facilities, for which space is available, would include compressors and hyperbaric chambers, plus 25 beds in the proposed new PHS hospital.

TRAINING

The hospital accepts trainees from the University of Texas Medical Branch, Galveston Community College, Alvin Junior College, and Community Action Programs. Alternative arrangements for the PHS training are apparently not currently available according to information provided.

Of special consideration is the relationship of the hospital with University of Texas Medical Branch. To a great degree the medical school's preplanning has included the PHS hospital in its expansion program which is currently up for consideration and approval by its Board. The University anticipated that the PHS would locate a modern general hospital to supplement University facilities on land provided by the University and deeded to PHS. Further, the University has obtained grants based on the number of health personnel to be trained and these commitments are directly related to utilization of the PHS hospital. University of Texas Medical Branch President Truman Blocker publicly announced on January 21, 1971, that enrollment of medical students for the next session would have to be reduced 20% if the PHS hospital were to be closed.

Currently residents in dermatology, neurosurgery, otaryngology, ophthalmology, and urology rotate through the PHS hospital. Twenty-three medical students took their elective 10-week training at the PHS hospital in medicine, ophthalmology, radiology, or surgery. Eighty students serve part of their clinical clerkships at the hospital. Forty students received their instruction in 10-week periods at the hospital. In addition, 22 nursing students, 48 physical therapy students and 3 medical record students received part of their instructions at the hospital.

Seven members of the hospital staff hold faculty appointments at the University.

Dr. Stewart Wolf, Professor of Marine Biology, noted the integral relationship planned for the PHS hospital and the Marine Biomedical Institute in the conduct of the "Man-in-the-Sea" Research Program. He stated that the PHS hospital was to be the focus of their activity as far as Man-in-the-Sea is concerned.

Mr. Marburger, Dean of Alvin Junior College, has 200 students enrolled in the Associate Degree Nursing Program and 56 of these received clinical training at the PHS hospital.

The President of Galveston Community College indicated that the college was currently offering educational opportunities to 200 students and has expansion plans which are contingent on utilization of PHS hospital clinical facilities. Currently 100 nursing students from this college receive clinical instruction at the PHS hospital.

Intra-mural Health Manpower Training Activities include aide training of Neighborhood Youth Corps enrollees in physical therapy, pharmacy, housekeeping, and dietary skills. Similar training of the handicapped is conducted in dietary and laundry procedures. Further, a 10-week summer work program has been developed for six youths selected by the Texas Employment Commission.

RESEARCH

The Galveston Hospital participates in cooperative research studies with the University of Texas and with the Man-in-the-Sea Program. While the hospital facility is presently essential to these programs, the relatively small amount of discussion about the programs indicates that alternative arrangements could be made.

ECONOMIC IMPACT AND EMPLOYEE PLACEMENT

The hospital's payroll is estimated at approximately $2,000,000 or about 1/3 of the total wage and salary income of the city. Its employment is just under 1% of the total city employment. Statements received indicate that removing this income and these jobs, could have an appreciable impact on an economy that is in good part dependent upon seasonal work in this resort city.

The effect on individual employees would be dependent upon their individual skills. Health Professionals and clerical employees could find employment, others would have great difficulty. The unemployment rate in the Galveston, Texas, area is 5.6%. For minorities it is nearer 9%. The employees most dif-

ficult to place will be the semiskilled and unskilled minority group employees that make up the great majority of the nonprofessional hospital staff.

Employment in other Federal agencies, with the opportunity to retain fringe benefits, appears nearly impossible. Total Federal Civil Service employment is only 1,062 in Galveston, which includes the hospital. If the hospital closes there would be only 831 civil service positions locally, 458 of these in the Corps of Engineers and 155 in the Post Office. Turnover in all Federal agencies has been very low recently and no increases in ceiling are expected.

The economic impact of the hospital closure on dependents and retirees was also emphasized. Several individuals pointed out that it would be a definite hardship for those at the enlisted level.

POTENTIAL USE FOR THE FACILITY

No definitive statements could be obtained as to planning for the use of the facility. Responsible planners point out that they have not had time to consider such a proposal. Others cited lack of local funding and the cost of remodeling the facility for other uses.

The recommendation of the University of Texas Medical Branch is to utilize the PHS facility for training of health manpower under the auspices of a local public educational institution.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, NEW ORLEANS, LA.

Operating Beds, 403
Workload (FY 1970):
- Average Daily Patient Load, 307
  - PHS Beneficiaries, 207
  - Others, 100
- Outpatient Visits, 145, 447
  - PHS Beneficiaries, 48,056
  - Others, 97,391

Budget FY 1971, $8,165,118
Per Diem Inpatient Cost (FY 1970), $47.53 (All inclusive)
Outpatient Visit Cost (FY 1970), $8.48 (All inclusive)
Personnel:
- Total, 629
  - Commissioned Officers, 140
    - Physicians, 92
    - Dentists, 10
    - Pharmacists, 15
    - Others, 23
  - Civil Service, 489
    - Nursing, 147
    - Dietary, 63
    - Housekeeping, 37
    - Laboratory, 37
    - Radiology, 13
    - Engineering and Maintenance, 38
    - Medical Records, 32
    - Other, 122
  - Commissioned Officer Trainees, 56
    - Medical Interns, 19
    - Medical Residents, 27
    - Dental Interns, 6
    - Others, 4

Facility:
- Date of Construction, 1932
- Size of Property, 17.2 acres
- Number of Buildings, 23
- Cost of Modernization, $21.9 million
- Potential Community Use, with alterations:
  - General Hospital
  - Extended Care Facility
  - Community Health Center

Summary of Site Visit to PHS Hospital New Orleans, January 18–19, 1971

CONSENSUS

The USPHS Hospital in New Orleans is recognized not only for the high quality medical care services it provides PHS beneficiaries, but also for its diversified activities in the training of health personnel, clinical and health services research, and community activities in support of the programs for the impoverished and disadvantaged. The hospital's patient load, both inpatient and outpatient, would be difficult to absorb.

PATIENT CARE

The USPHS Hospital in New Orleans provides a complete inpatient and outpatient medical care program, including all specialties, and special care services, such as intensive care, coronary care, renal dialysis, and burn care. Statistics for one year indicate 57,300 hospital days and 145,000 outpatient visits. There is no DOD hospital in the New Orleans area and the VA hospital of 581 beds (report an occupancy rate of 85.5%) indicates that other Federal hospital systems cannot be looked to to absorb any significant portion of the USPHS hospital medical care load.

A recent review reveals that the New Orleans area has 5848 community hospital beds with a total occupancy rate of 78%. Medical-surgical beds available number 3500 with an occupancy rate of 89%, and all major hospitals reported a waiting list. It was the expressed opinion that the community's major hospitals, offering complete medical care services similar to those provided by the PHS hospital, could not absorb the PHS hospital patient load, pending further expansion through construction.

HEALTH SERVICES TO THE COMMUNITY

For the State and area, the hospital participates in disaster planning and care, provides support for the State crippled children program, and maintains a 24 hour a day poison control center.

For the city, the hospital provides such things as: (1) New Orleans' only burn unit, (2) a variety of training through its staff and through use of facilities for participants in educational and community programs, (3) volunteer professional and technical staff for community clinics, (4) health care planning support for community groups, (5) health care for a number of disadvantaged unwed mothers, (6) physical examinations and some care for disadvantaged children participating in a Federally funded day care center program, and (7) training materials for medical and technical schools.

Members of the community stressed that the hospital was carrying on many of these activities because no other resources or facilities were available.

TRAINING

Each year the hospital trains 18 medical interns and six dental interns and currently has a resident staff of 34. Tulane medical students serve clinical clerkships throughout the hospital. A physical diagnosis course is taught students in the sophomore class. The hospital has a school of medical technology affiliated with colleges in the New Orleans area and provides senior and postgraduate training for enrollees. Students from the Loyola School of Medical Technology spend their final year of training in the Pathology Department. Physical therapy students from the Universities of Florida and Alabama get practical experience in the hospital. In nursing, the hospital provides experience for students from the Hotel Dieu, Touro, and Dillard University Schools of Nursing.

The hospital provides the practical experience segment of the L.P.N. training program of the New Orleans Parish School Board. The hospital trains X-ray technicians, community health workers, medical secretaries, lab technicians, and a variety of other hospital workers through cooperative community hospital programs.

Over 40 members of the professional staff serve as faculty at Tulane, LSU, Loyola, and Xavier. The staff is also active in the support of school and community training programs.

RESEARCH

The hospital research program includes both clinical and health services research. Much of the research is carried on in cooperation with Tulane University and is supported by the National Institutes of Health. Programs in existence at present include: heart, cancer, respiratory, vascular, renal, endocrine, and metabolic studies.

The health service research, again primarily in cooperation with Tulane University, has been in two major areas. The first has been concerned with computerizing certain hospital functions including menu planning and medical records. The second is an automated multiphasic screening project.

Other projects include investigation of outpatients visits costs, broken appointments, the social-psychological-physiological impact of physical illness and hospitalization, the acceptability of fire resistant hospital linens, and drug costs.

ECONOMIC IMPACT AND EMPLOYEE PLACEMENT

In normal times, if the hospital were to close, the hospital employment of 600 and payroll of approximately $6,000,000 would not be a major loss to a city as large as New Orleans. At the present time, with unemployment at 6% (for minorities 9%), local officials term it a crisis.

Health care jobs are scarce for all but a few health professionals. Nurses, for instance, continue in high demand at good salaries. The semi-skilled and unskilled would be difficult to place in comparably paid positions. Minority group members, the bulk of the nonprofessional staff, would have an especially hard time.

Federal employment in the New Orleans area has dropped from a peak of 16,500 to a present level of 13,000 and continues to decline. Few vacancies, aside from clerical positions, were reported in a city-wide survey of Federal agencies.

POTENTIAL USES OF FACILITIES

Representatives of training and community groups stated that the time given for them to study the potential impact of closing the hospital was insufficient to make any plans concerning uses of the facility. Both groups stated that funds and manpower are not presently available in the local area or the State to operate the hospital.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, NORFOLK, VA.

Operating Beds, 210
Workload (FY 1970):
- ADPL, Total, 142 (67.6% occupancy rate)
  - PHS Beneficiaries, 71
  - Others, 71
- Outpatient Visits, Total, 92,983
  - PHS Beneficiaries, 24,443
  - Others, 68,540

Budget FY 1971, $4,052,255
Per Diem Cost (FY 1970), $61.04 (Average Length of Stay, 15.7 days)
Outpatient Visit Cost (FY 1970), $9.13
Personnel:
- Total, 332
  - Commissioned Officers, Total, 42
    - Physicians, 25
    - Dentists, 6
    - Pharmacists, 5
    - Other, 6
  - Civil Service, Total, 290
    - Nursing, 101
    - Dietary, 34
    - Housekeeping, 22
    - Laboratory, 16
    - Radiology, 10
    - Engineering and Maintenance, 19
    - Medical Records, 16
    - Other, 72

Commissioned Officer Trainees (included in personnel figures above):
Medical Interns, 2
Other, 3
Total, 5
Facility:
Date of Construction, 1922; new wing added 1934
Size of Property, 21.4 acres
Number of Buildings, 11
Cost of Modernization, $13.5 million
Potential community use, with moderate alterations:
General Hospital
Extended Care Facility
Community Health Center

SUMMARY OF SITE VISIT TO NORFOLK PHS HOSPITAL, JANUARY 21-22, 1971

I. PATIENT CARE

A. Discussions were held with key health leaders from the Community to determine the capacity of local health resources to absorb patient workloads should services provided by Norfolk PHS Hospital be discontinued.

1. *Inpatient resources.*—At the present time the occupancy rate in Norfolk for non-Federal medical-surgical beds is 90.8% with waiting times *of 3 to 4 weeks* for some elective admission. Local hospital representatives stated that medical-surgical bed shortages are critical and additional demands would further aggravate accessibility to inpatient care. No cost data for inpatient care at private hospitals was provided by the group. Estimates provided by patients revealed that the per diem cost is over $100 per day.

2. *Outpatient resources.*—A recent survey by the City Health Department indicated that 43% of the population had no primary physician. The 3 hospitals outpatient clinics are operating at maximum capacity. Representatives from the County Medical Society reported that the 564 physicians in the area were overtaxed and some had waiting times for appointments of 4 months. The 90,000 visits in the Norfolk PHS hospital would be a burden on local resources.

3. *Dental Care.*—Representatives from the local Dental Society stated that they now had waiting periods of 4 months for routine dental care.

4. *Other Considerations.*—Community leaders felt much more time is necessary to fully evaluate the effect closure action would have on the community and the beneficiaries.

5. *Impact on Other Federal Facilities.*—The Portsmouth Naval Hospital with 1,800 beds is the nearest military hospital serving the 350,000 Department of Defense active duty, retired and dependents in the area. In addition, there are several military outpatient clinics located in the Tidewater area. The Commanding Officer of the Portsmouth Naval Hospital stated that his facility could absorb DOD beneficiaries being cared for at the PHS Hospital. Presently the Norfolk PHS Hospital provides 60,000 outpatient visits and 1,400 hospital admissions to DOD beneficiaries. The Commanding Officers of the military outpatient clinics disagreed with the Commanding Officer of the Portsmouth Naval Hospital, stating that the impact on their facilities would increase waiting periods from the present 2 hours to as much as 4 and 6 hours.

The Veterans Administration Hospital in Hampton operates a total of 645 beds. The VA representatives had no comment on the ability of this facility to absorb additional patient loads.

B. Beneficiary reactions to possible alternatives

1. *American Seamen.*—Seamen are opposed to alternative arrangements for medical care stating that the PHS hospitals are their primary source of care, the personnel are familiar with their needs, and that they can always go to a PHS hospital for care but cannot always find other resources.

2. *Uniformed Service Personnel.*—Dependents and Retirees indicated that the Uniformed Service facilities in the area are crowded and in many cases inconvenient. Cost for transportation to the Portsmouth Naval Hospital for those beneficiaries living in Norfolk is a significant factor for retirees and dependents of enlisted men. The CHAMPUS program from their view is not satisfactory because (a) the deductibles create a financial hardship, especially for retirees and families of lower grade enlisted personnel; (b) many private doctors do not wish to participate in CHAMPUS and the patient must fill out complicated forms for reimbursement.

II. IMPACT ON TRAINING AND EDUCATIONAL INSTITUTIONS

A. Medical Schools: The Norfolk Area Medical Center Authority is working toward establishing a medical school in Norfolk and hopes to admit the first students in September 1972. It is planning on utilizing the Norfolk PHS Hospital as a training resource for medical students and is particularly interested in seeing the Norfolk PHS Hospital relocate to the Norfolk Medical Center.

B. The Eastern Virginia Interhospital Medical Education Committee is presently working on plans for coordinating all professional training programs in the area. Trainees would rotate through various training facilities including the PHS Hospital.

C. Old Dominion University: The University utilizes the PHS Hospital for training of dental hygienists, nurses, and bacteriologists.

D. Norfolk State College: This is a predominantly black college and many of their students are from the indigent population in Norfolk. The PHS Hospital is utilized for clinical training of nurses.

E. Physical Therapy Affiliations: The Medical College of Virginia, the University of Penusylvania, and Marquette University use the PHS Hospital for clinical training of physical therapists.

F. Programs for the Unemployed: The Hospital has, since 1965, provided on-the-job training for the Neighborhood Youth Corps Program. At present 15 trainees are assigned to the Hospital.

G. The City Health Department, the Model Cities Project, and Medical College of Virginia have, or are planning to develop, training affiliations with the Hospital for the training of health personnel.

III. RESEARCH

Except for cooperation in the PHS system-wide study on pyelonephritis medical research is carried out on an individual basis. The hospital has no formal clinical research program.

IV. COMMUNITY PROGRAMS

A. The only equipment in the Norfolk area for photocoagulation used in eye surgery is located at the Hospital and is used by local practicing ophthalmologists.

B. The Hospital has the only completely trained medical social service staff available in the Norfolk area and is heavily utilized by military dependents. In addition, students from the School of Social Work, Virginia Commonwealth University, affiliate at the hospital.

C. Private physicians refer patients to the Hospital for clinical evaluation of complicated medical problems.

D. In the past year the Norfolk community has requested that services at the Hospital be made available to medically deprived populations within the community. The private resources in Norfolk are overburdened and cannot meet the medical needs in the area. The comprehensive care provided at the Hospital offers a unique asset for upgrading the quality of care among the lower income groups in the community.

V. EMPLOYMENT

The employment situation in Norfolk, Virginia, is not conducive to assimilation of the present staff at the hospital. There are approximately 53,000 Civil Service employees, 10,000 white collar, 23,000 blue collar, and 10,000 postal workers. The military hospital and dispensaries are staffed with military personnel as well as civil servants. The findings indicate small turnover in the Civil Service employees and stringent budget and ceilings problems. The City of Norfolk (including the private sector) is seriously handicapped by tight budgets and fiscal support. One private hospital (a 200 bed installation) may be closed in the near future for these very reasons.

There were, as of January 10, 1971, 91 persons on the Civil Service Commission's separated career employment list. The study team was advised that this does not reflect the impact on placing career Civil Service employees. The DOD has placed "Stop" orders on hirings within the DOD installations in order to place employees being phased out or "riffed", thus many persons do not file with the Civil Service Commission.

Norfolk's unemployment rate has gone from 3.9% to 4.0% over the last few months.

VI. ECONOMIC IMPACT

The City of Norfolk is not in a strong economic position at the present time. It was stated that the loss of over four million dollars per year in local expendable income would have a serious impact on the total economy with a far-reaching effect into industries other than health.

VII. ALTERNATIVE USES OF FACILITIES

There were two proposals for possible alternative nses of the hospital: (1) to incorporate the hospital as part of the proposed Eastern Virginia Medical College and (2) to convert the hospital to a drug abuse center. Both suggestions would require continued Federal support.

Mr. Porter Hardy, among others, declined to discuss alternatives, so adamant was their position that the hospital should not close. The Tidewater Planning Council indicated that a minimum of six months would be required to accumulate and analyze data which would lead to definitive proposals.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITALS, SAN FRANCISCO, CALIF.

Operating Beds, 366
Workload (FY 1970):
- ADPL, Total, 250 (68.3% occupancy rate)
  - PHS Beneficiaries, 197
  - Others, 53
- Outpatient Visits, Total, 118, 574
  - PHS Beneficiaries, 78, 591
  - Others, 39, 983

Budget FY 1971, $9,956,737
Per Diem Cost (FY 1970), $59.54 (Average Length of Stay, 17.4 days)
Outpatient Visit Cost (FY 1970), $15.41
Personnel:
- Total, 672
  - Commissioned Officers, Total, 156
    - Physicians, 109
    - Dentists, 14
    - Pharmacists, 8
    - Other, 25
  - Civil Services, Total, 516
    - Nursing, 157
    - Dietary, 59
    - Housekeeping, 39
    - Laboratory, 24
    - Radiology, 20
    - Engineering and Maintenance, 37
    - Medical Records, 27
    - Other, 153

Commissioned Officer Trainees (included in personnel figures above):
- Medical Interns, 20
- Medical Residents, 28
- Other, 8
  - Total, 56

Facility:
- Date of Construction, 1932; alterations and additions 1953.
- Size of Property, 36.4 acres
- Number of Buildings, 25
- Cost of Modernization, $12.6 million
- Potential community use, With minimal alterations
  - General Hospital
  - Extended Care Facility
  - Community Health Center

SUMMARY OF SITE VISIT TO PHS HOSPITAL, SAN FRANCISCO, JANUARY 21–22, 1971

INTRODUCTION

The following is a summary of the information and findings discussed during the site visit to San Francisco on January 20–22, 1971.

PATIENT CARE

Primary beneficiaries, such as American Seamen, the Coast Guard, and dependents, are confident that other medical care resources will not be as responsive to their health care needs and that local Federal and non-Federal resources are already overloaded.

Other beneficiaries, such as uniformed services dependents, as well as retired personnel and dependents, are experiencing increasing difficulty in obtaining medical care through the local Department of Defense (DOD) facilities. The DOD medicare program. OCHAMPUS, is not considered a satisfactory alternative because of the episodic, discontinuous nature of medical care obtained through private resources and the costs of the deductible provisions.

The Commanding Officers of the Letterman Army Hospital and Oak Knoll Naval Hospital stated that their facilities could handle the active duty Coast Guard patient load but that they would not be able to absorb dependents or retired personnel without an increase in budget and staffing. Letterman is currently operating at 520 beds, with 525,000 annual outpatient visits, and could not handle any increase in ambulatory care workload nor provide any dental care. The Oak Knoll Naval Hospital, which is 12 miles from the Alameda Coast Guard Base, could handle Coast Guard active duty personnel. It would have major problems with ambulatory care and would be unable to handle dental care except for the Coast Guard. The Navy would have problems providing psychiatric services since its program is operating at full capacity including Air Force referrals. Hamilton Air Force Base, 25 miles north of San Francisco, has a 55-bed hospital which may be reduced to dispensary status next year. With an anticipated cutback in personnel, it could not absorb any additional ambulatory care or dental work. Other DOD ambulatory care facilities exist at the Oakland Army Base, the Tracey Army Depot, and Naval Dispensaries at Treasure Island, Moffitt Field, and Mare Island. Distance and existing workloads make these inadequate backup resources.

The Coast Guard station at Alameda provides routine ambulatory care to that Base's population and operates a special mental health program for the Coast Guard recruits. All specialty services, laboratory backup, hospitalization and oral surgery are provided by the Public Health Service Hospital.

The Merchant seamen are strongly opposed to the use of the Veterans Administration for their medical care, and they are supported by the local Veterans organizations. The four VA facilities in the Bay area are at Fort Miley (352 beds), Martinez (498 beds), Livermore (400 beds), and Palo Alto (1,769 beds, including 1,218 NP beds). These hospitals all have occupancies at 80% or higher. Their ambulatory care resources are unable to assume additional workload, and no dental care could be provided. With the exception of Fort Miley, all are in excess of 35 miles from San Francisco.

The community general hospitals have a current occupancy of 72.5% for medical and surgical beds. However, representatives from the San Francisco Hospital Conference and the Planning Agency did not consider this a true indicator of capacity since this census is caused by the present economic situation, and does not reflect types of services provided, nor geographic distribution. Few of the hospitals have ambulatory care programs, and, if expanded, they would have to meet local community demands rather than Federal beneficiary needs. In order to assess the community's capacity to provide equivalent medical care to Federal beneficiaries, more specific information on community resources must be obtained.

The Maritime Claims Industry representative reported that any alternative medical program must provide rapid access, evaluation, treatment and return to duty for the Merchant seamen in order to avoid substantial increased costs to the industries in extended disability benefits and delay in processing claims. The Bureau of Employees' Compensation, Department of Labor, Medical Director stated that, in that agency's experience, the transfer of treatment of Federal employees to the private sector would result in a significantly increased cost to the Federal Government.

TRAINING

At the University of California, more than 60% of all clinical training for the professional schools is conducted off campus. The major institutions are the San Francisco General Hospital, the PHS Hospital, and the VA Hospital. All medical students receive some portion of their training at the PHS Hospital. The present entering class size is 144, will increase to 150 in September

and is projected to be 200 by 1980. Off campus programs will be essential to this expanded student enrollment since no on campus clinical facility expansion is planned. In addition, the PHS staff provides a significant portion of the clinical teaching on campus, particularly in the ambulatory clinics.

PHS clinical facilities, patients, and staff are also essential elements in the Dental Programs of the University of California and College of Pacific, Nursing Programs of the University and other allied health programs.

With respect to post-graduate education, the University of California and its affiliated programs would not be able to absorb additional PHS trainees since in the internship and a number of the residences, the programs are already staffed to their capacity and are having problems with accreditation. The PHS Hospital also supports local vocational education and related programs.

RESEARCH

The PHS Hospital conducts major research in cardiovascular physiology, cardiovascular disease, metabolism, endocrinology, renal disease, dentistry, and leprosy. The major source of support for the cardiovascular, metabolic and endocrine studies is NASA which has and continues to support this large scale clinical research program. It is studying the effects of weightlessness in man.

Dental research projects include both independent studies as well as studies supported by NIDR and the Dental Health Center. At the present time, over 500 patients are being followed in these projects, and follow-up of a significant portion of these patients would be necessary.

The San Francisco Hospital has been the leader in a cooperative six PHS Hospital study on the treatment of mild to moderate hypertension. This program is supported by a NIH grant which has recently been recommended for a five-year renewal. At the present time, 340 patients are being followed in these six hospitals.

The San Francisco Hospital is also one of four PHS hospitals supported by NIH as a participant in the National Coronary Drug project. They are members of 50 clinics studying the effectiveness of cholesterol lowering agents in prolonging survival and reducing morbidity after a myocardial infarction. San Francisco is following 142 patients.

COMMUNITY PROGRAMS

The extent of involvement of the San Francisco PHS Hospital in community health service programs was emphasized in meetings with representatives from educational institutions, local health agencies and institutions, private physicians and dentists, and citizens of the community.

One unique program is the Leprosy program involving diagnosis, treatment and research on that disease. Initiated in 1965, this program has 314 patients under treatment on an ambulatory basis and is following approximately 1,000 contacts. Ambulatory followup is also provided through PHS Clinics in San Diego and San Pedro under the supervision of the San Francisco program which has its own ambulatory clinic and handles all hospitalizations for California. This service has established an international reputation in its own NIH supported program, provides laboratory support to international research projects. It also serves as a training facility for U.S. and foreign scientists.

The San Francisco Hospital initiated a chronic renal dialysis program under a NIH grant as part of the University of California transplantation program. It has become a part of Northern California's community dialysis program in collaboration with the dialysis unit at the San Francisco General Hospital and the University's transplantation program. At the present time, approximately 150 patients are receiving chronic dialysis in the Northern California program, of whom 35 to 40 require treatment in hospital units. Of these, 15 patients are receiving treatment at the San Francisco General Hospital and 12 are receiving treatment in the San Francisco PHS Hospital (approximately 30%). The remainder of the patients are on home dialysis, and 80% wait for at least a year before receiving a kidney transplant. At the present time, the University of California performs 80 to 100 transplants a year. In addition to PHS beneficiaries, the PHS unit is taking care of VA beneficiaries, residents from San Francisco and Northern California on a reimbursable basis and, in the past, 4 Indian Health Service beneficiaries have received treatment. The present 12-bed PHS unit represents 25% of the Bay area's hospital dialysis capacity.

In May of 1970, the PHS Hospital developed a Community Mental Health Center program in its District at the request of the community citizens and local Mental Health officials. The program provides 24-hour emergency coverage, ambulatory and inpatient care, consultative services to schools and other community agencies, is a training ground for mental health workers, and was initiated without Federal funds, using State, local and private funds.

The hospital has also developed an alcohol and drug detoxification unit to serve both primary beneficiaries, as well as the community. Except for a 20-bed unit in the San Francisco General Hospital, this is the only inpatient detoxification center in San Francisco. This program was also initiated without Federal funds.

Another community program under development is an emergency medical service for the Richmond community and District 5. Under normal circumstances, emergencies are taken by ambulance to a District Aid Station, a 50-year old facility scheduled for phasing out. The nearest emergency facility will then be San Francisco General. The community and the Committee are encouraging the Shrine Hospital in the Sunset District to provide emergency services, but the optimum resource would be the PHS Hospital.

The PHS Hospital is participating in a special study in collaboration with the American Heart Association to evaluate the City's coronary care units. In addition, a pilot project on pre-hospital coronary care has been designed involving the training of ambulance attendants and the utilization of ambulances with cardiac monitoring equipment and a central communications facility.

Representatives from the community's health and other voluntary agencies, public officials, and citizens stated that instead of phasing out programs, the role of the PHS facility should be broadened to provide greater community services. Furthermore, based on their assessment of community resources in terms of manpower, facilities and funds, it was their opinion that none of these programs could be transferred to other community agencies or institutions. The Deputy Mayor of San Francisco said that State and local government funds were insufficient to support these community programs since there are so many other unmet health needs in the community.

EMPLOYMENT

Preliminary data and information obtained from Federal and community agencies indicate that employment of the staff below physicians and dentists in the community will be extremely difficult. As in other parts of the country, there has been large cutbacks and closures of Federal facilities and programs.

The average unemployment rate is 6%, estimated to be 12% in the services and trades, and perhaps as high as 25% in the inner city population. The Federal registers are overstocked with applicants. Local hospital officials reported that the economic situation has reduced hospital utilization, forcing a cutback in employment and a surplus of job applicants for vacancies in the health field.

Another significant problem is that some Federal employees may not be qualified for comparable employment in the private sector. For example, laboratory technicians, representing 75% of the laboratory staff, can only be employed in Federal hospitals or research laboratories. These technicians are not licensed and cannot work in California hospitals or clinical laboratories. A similar problem exists for licensed vocational nurses.

ALTERNATE USES OF THE FACILITY

Due to the limited time for preparing for the site visit, community participants had insufficient information to discuss this issue. There is also a legal question, since existing law requires that, if the PHS discontinues operation of the San Francisco facility, title reverts to the Department of the Army.

SUMMARY

In all the discussions on the PHS program in San Francisco, there were no statements which supported the redirection of the medical care program and the phasing out of the hospital as a Federal facility. It was emphasized repeatedly that any decision affecting the hospital program will require the collection of more detailed data, analysis by all community interests, and a more reasonable schedule for implementation.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, SEATTLE, WASHINGTON

Operating Beds, 262
Workload (FY 1970):
- ADPL, Total, 180 (64.5% occupancy rate)
  - PHS Beneficiaries, 75
  - Others, 105
- Outpatient Visits, Total, 112,120 (includes 17,000 dental visits)
  - American Seamen, 31,508
  - BEC, 2,239
  - Coast Guard, 9,881
  - PHS C.O., 1,218
  - Special Study, 2,113
  - Dept. of Defense, 13,044
  - Dep. DOD, 34,720
  - Dep. CG, NOA, & PHS, 9,444
  - Other, 7,953

Budget FY 1971, $7,403,132
Per Diem Cost (FY 1970), $63.00 (includes physician salaries)
Average length of stay, 12.9 days
Outpatient Visit Cost (FY 1970), $14.01
Personnel:
- Total: 520
  - Commissioned Officers, Total, 113
    - Physicians, 68
    - Dentists, 16
    - Pharmacists, 9
    - Other, 20
  - Civil Service, Total, 407
    - Nursing, 116
    - Dietary, 49
    - Housekeeping, 30
    - Laboratory, 35
    - Radiology, 13
    - Engineering & Maintenance, 22
    - Medical Records, 17
    - Other, 125

Commissioned Officer Trainees (included in personnel figures above):
- Medical Residents, 25
- Other, 14
- Total, 39

Facility:
- Date of Construction: 1932; additions 1953
- Size of Property, 9.9 acres
- Number of Buildings, 9
- Cost of Modernization, $19.7 million (new hospital building)

SUMMARY OF SITE VISIT TO THE SEATTLE PHS HOSPITAL, JANUARY 18–19, 1971

PATIENT CARE

The National Oceanic and Atmospheric Administration depends entirely on the Public Health Service hospital for the care of its members. They have approximately 800 individuals including dependents and retired in the Seattle area and of this number approximately 500 are seagoing. The services furnished by the hospital to this group are primarily physical examinations and dental care.

The Coast Guard has 2,300 active duty in the 13th District and of this number 1,100 are in Seattle. In addition, there are approximately 1,600 dependents and 1,100 retired in the 13th District. The PHS hospital also provides inpatient care to Coast Guard personnel referred from the 17th District in Alaska. The present staffing compliment of the 17th District is 325 active duty and 510 dependents. The Coast Guard representative advised that though there are some problems with the present system of providing care to Coast Guard personnel by the Public Health Service hospital, their medical care needs are being satisfied and they do have assurance that their families are being cared for.

Madigan (Army) located between Tacoma and Olympia, Washington (approximately 45 minutes to an hour from Seattle) is not admitting retired or Coast Guard personnel. Madigan has an average inpatient ADPL of 750 and approximately one million outpatient visits per year. With increased financial resources they could expand the inpatient ADPL to approximately 1,200.

The Bremerton Naval Hospital (four to five hours from Seattle and a $6.00 ferry ride) is not currently admitting retired or dependents. The Bremerton Naval Hospital is currently experiencing an inpatient ADPL of 140–150 and 10 to 12,000 outpatient visits per month. It was indicated that they could expand their capacity to some degree with increased resources though would continue to rely on Madigan for specialty services such as psychiatry.

Compounding the problem of lack of capacity for dependents at Navy and to a lesser degree at Army, is the fact that 80% of the total Coast Guard active duty compliment earn a salary below the minimum wage. Due to the deductible feature of CHAMPUS financial hardship would be imposed on this group. A major problem related to CHAMPUS is the location of a physician who is willing to provide the services.

The National Oceanic and Atmospheric Administration, Coast Guard, Navy, Army, Indian Health Service, and the Bureau of Prisons all utilize the PHS hospital for both inpatient and outpatient care and this includes a substantial number of dependents and retired of the Department of Defense Agencies. At the present time the Department of Defense and Veterans Administration facilities do not have the capacity to take the load presently handled by the PHS hospital, other than active duty Coast Guard at Navy and possibly Army. It was pointed out by the various Federal agency representatives that if there was sufficient time allowed for planning over the next few years, it is possible that adequate arrangements could be made to accommodate the patient load resulting from a phasing down of the PHS hospital operation.

The Seattle private sector is currently experiencing an average occupancy rate of 70%. From the outset this is an indication that there are beds available in the community for which the Federal government could make contract arrangements. It was pointed out, however, that to increase capacity would require resources and that this could be accomplished through careful planning over a period of time, projected to be 2 or 3 years.

HEALTH SERVICES TO COMMUNITY

The PHS hospital serves as a backdrop in the Seattle community for emergency health services. It also has facility for and is the focal point for treatment of contagious disease. Clinics are currently being operated three nights a week on a volunteer basis for the provision of care to urban Indians in the Seattle area who are not otherwise entitled to care. 750 Indians were treated in these clinics during the past year. The hospital also conducts a family planning clinic and participates with other hospitals in the community on an exchange of services arrangement as provided for under Section 328 of the Partnership for Health Amendments of 1967 (PL 90–174).

TRAINING AND EDUCATION

The most extensive training program affiliation is with the University of Washington. The current University building program plans call for a 50% increase in basic science space to be utilized for health teaching. The 1971 medical school enrollment will be 102 with plans to increase this number to 125 and nursing students to 1,000 in the fall of 1972. Though the University also has affiliations with Children's, Orthopedics, and VA Hospitals it relies heavily on the clinical environment of the PHS hospital. Of all of the hospitals the Public Health Service is rated the highest by the medical students, interns and residents. There is a common internship program at the University with the interns rotating through the PHS hospital. A number of the PHS hospital staff have faculty appointments at the University. Family practice residents rotate through the PHS hospital and 30% of Core teaching is conducted at the PHS hospital. Dr. Hogness and Dr. Van Citters made a strong plea that if a decision is to be made to phase out the PHS hospital, such action should be over a period of time sufficient to allow the University an opportunity to acquire sufficient additional clinical beds to serve its needs.

There are a number of training affiliations with the PHS hospital such as the Seattle Central Community College for training in dental technology and dental assistants, Seattle University for nursing students, and Providence Hospital for medical records students.

RESEARCH

The Division of Oncology of the University of Washington utilizes approximately 12,000 square feet of space on the 10th and 7th floors of the PHS hospital, and employs 56 individuals including 14 physicians all of whom work at the PHS hospital. Activities of the Division include a clinical cancer center of 8 beds including two laminar air flow rooms, histocompatibility typing, which provides tissue typing service for the entire western United States, and laboratory research activities. It has been clearly established by Dr. Hogness and Dr. Van Citters that there is not now, nor will there be in the near future, space to accommodate the Oncology Division.

The PHS hospital also has a research laboratory in Endocrinology and Reproductive Physiology, has a research training unit for individuals who desire a career in academic medicine, participates in cooperative study programs involving hypertension and renal disease, has an Infectious Disease Laboratory which serves as a central referral center for patients with urinary tract infections, conducts research in cardiology, gastroenterology, nephrology, special hematology, pulmonary function, nuclear medicine, pyleonephritis, pathology and dentistry, and operates a fully integrated physical medical and rehabilitation service.

ECONOMIC IMPACT AND EMPLOYEE PLACEMENT

The Seattle area is currently experiencing a contraction in industry, the most significant of which is a reduction in operations at Boeing Aircraft. Unemployment in the Seattle area is currently approximately 12–13%. The effects of this unemployment are being spread across all categories of employment with significant impact on the minorities. In querying the status of employment in medical care institutions, it was revealed that there is a very low rate of turnover. A one day survey of all the hospitals on Sunday, January 17, 1971, indicated that there were no more than 22 nursing vacancies in the entire Seattle area. It was repeatedly emphasized by representatives of the community groups, that if the PHS hospital were to close in the near future and approximately 400 individuals were to be placed on an already critical employment market, the impact on the community would be severe.

POTENTIAL USE OF FACILITY

There were a number of ideas expressed over the potential use of the PHS hospital facility ranging from continued operation as a PHS hospital, to a hospital resource for the community, a hospital to be under the jurisdiction of the University of Washington, a possible hospital resource for the VA, and a private corporate consideration such as the HMO concept. None of these notions were with foundation but rather were spontaneous suggestion and included the need for careful exploration into the community to determine requirements and to plan accordingly.

FACT SHEET ON U.S. PUBLIC HEALTH SERVICE HOSPITAL, STATEN ISLAND, NEW YORK

Operating Beds, 636
Workload (FY 1970):
    ADPL, Total, 420 (66.0% occupancy rate)
        PHS Beneficiaries, 268
        Others, 152
    Outpatient Visits, Total, 142,806
        PHS Beneficiaries, 72,360
        Others, 70,446
Budget FY 1971, $13,675,067
Per Diem Cost (FY 1970), $60.46 (Average Length of Stay, 19.5 days)
Outpatient Visit Cost (FY 1970), $14.82

Personnel:
- Total, 1,060
  - Commissioned Officers, Total, 235
    - Physicians, 162
    - Dentists, 16
    - Pharmacists, 14
    - Other, 43
  - Civil Service, Total, 825
    - Nursing, 227
    - Dietary, 126
    - Housekeeping, 59
    - Laboratory, 53
    - Radiology, 38
    - Engineering and Maintenance, 74
    - Medical Records, 41
    - Other, 207

Commissioned Officer Trainees (included in personnel figures above):
- Medical Interns, 30
- Medical Residents, 68
- Other, 24
- Total, 122

Facility:
- Date of Construction, 1935; additions 1942 (some buildings in use were constructed in 1883)
- Size of Property, 24.1 acres
- Number of Buildings, 17
- Cost of Modernization, $26.9 million
- Potential community use, with extensive alternations:
  - General Hospital
  - Extended Care Facility
  - Community Health Center

SUMMARY OF SITE VISIT TO PHS HOSPITAL STATEN ISLAND, JANUARY 21–22, 1971

The Staten Island Public Health Service Hospital is the largest single provider of health services on the island and along with the St. Albans Naval Hospital are the only inpatient facilities available for the uniformed service beneficiaries, their dependents, and retired personnel in the Greater New York area. Uniformly beneficiaries, community organizations, education institutions, and all health provider groups opposed any change in the hospital's status at this time.

PATIENT CARE

In 1970 there were nearly 8,000 admissions for inpatient care and 143,000 outpatient visits. Of the inpatient admissions, one-quarter on the average have permanent addresses on Staten Island, 40% have other New York City addresses. The hospital represents a regional care center with its responsibilities extending as far south as Philadelphia, and north to Cape Cod.

There are three voluntary and one proprietary hospital on Staten Island. They have a combined bed capacity of 642 medical/surgical beds and are operating at over 100% occupancy. These hospitals send their overflow to the Public Health Service Hospital where they are admitted as emergencies. It should be pointed out that 95% of the residents receive care on Staten Island. There is no municipal hospital.

The logistics involved in using the other boroughs, in the opinion of the community representatives, made their use too difficult. The bed occupancy in New York City for medical/surgical beds for 1970 is listed as 92% for voluntary hospitals, 89% for proprietary and 80% for the City Hospital System. For fiscal year 1971, allowable per diem hospital rates under Medicaid in the New York City area were running at approximately $94, excluding physician fees. This figure does not represent hospital costs which are higher. The Health and Hospital Corporation of New York, which operates the city hospitals, is using an all inclusive rate of $113 per day. The USPHS Hospital on Staten Island experienced

an all inclusive cost of about $63 per day in the operation of the hospital during fiscal year 1970.

The non-Federal ambulatory care facilities on Staten Island are severely overtaxed. Only two hospitals have outpatient facilities. They record 103,000 visits per year. The hospital which is the major supplier of ambulatory care will have to close this service in March 1971 unless money is forthcoming from State/City.

Over the last several years there has been a marked reduction in the availability of military health services in the area which has affected not only the active duty personnel but to a much greater degree the dependents and retired personnel. The St. Albans Naval Hospital is the only other inpatient facility in the area and has an authorized bed capacity of 800, although it is currently staffed to provide care much closer to its current census of 650 inpatients. The Army medical installations in the area consist of a comprehensive outpatient facility at Fort Hamilton and very limited clinics in Bayonne, New Jersey and the Brooklyn Terminal Fort Hamilton is currently handling 1,200 outpatient visits a month and refers to the Public Health Service Hospital the majority of dependents and retirees requiring hospitalization with active duty personnel being referred to St. Albans. In 1970, Army personnel represented 7,000 days of hospitalization at the Staten Island Public Health Service Hospital and over 16,000 outpatient visits were provided to their beneficiaries.

Coast Guard personnel in the third Coast Guard District consist of an active duty population of 5,000, a dependent population of approximately 7,500 and an estimate of nearly 3,000 retired people. The only medical facility which they operate in the area is a small dispensary with 5 physicians and 7 dentists on Governor's Island. In 1970, there were approximately 1,500 Coast Guard inpatient admissions to the PHS facility of which ⅔ were active duty personnel. Given the constricting patient care capability of St. Albans it is unlikely that active duty personnel would be fully provided for and nearly all the military dependents in the area would have to be referred to the OCHAMPUS program. The Army command indicated that their beneficiaries have had extensive experience with OCHAMPUS and it was not aware of problems in connection with its use.

The Bureau of Employees' Compensation expressed great concern about a change in their relationship with the Staten Island facility and with the outpatient clinic in Manhattan. In fiscal year 1970, BEC had 376 admissions and 11,000 outpatient visits at the hospital and an additional 16,000 outpatient visits at the New York Outpatient Clinic. It was categorically stated that alternatives to this kind of care would be exceedingly difficult to come by in the New York City area, that the cost of such alternatives would be very high and that the delays in the processing of fitness exams and the handling of compensation evaluations would result in additional large losses of productivity to the Government.

HEALTH SERVICES TO THE COMMUNITY

Staten Island is one of the five boroughs (Borough of Richmond) of New York City which can be reached by ferry or the Verrazano-Narrows Bridge. In the past decade (1960–1970) Staten Island has increased in population from 200,000 to 300,000, an increase of 50%. Because of its geographical isolation, the great majority of the Island residents obtain hospital care in hospitals on the Island. Conversely, very few non-residents use these facilities.

The PHS Hospital assists the community by absorbing its excess and emergency patient loads, and the community depends on the PHS Hospital for consultation and special services. Only one hospital has a renal unit and this unit has a 6–9 months waiting list. The physicians use the PHS for consultation and refer complex cases to the PHS Hospital which has a special renal section (research), including renal dialysis capability. The PHS Hospital is also pressed into community service for cardiopulmonary consultation and diagnostic studies, use of artificial lung, cobalt therapy, diagnostic isotope screening, provides heliport service for medical emergency, participates with community hospitals in local blood and emergency medical supply programs, participates in emergency and disaster planning in the community, and provides medical examinations, screening lab tests, follow-up medical care, and health education programs for the disadvantaged (Silver Lake Lodge Family Day Care Center, Staten Island Mental Health, Head Start Program, and others).

TRAINING AND EDUCATION

Community training affiliations

The PHS Hospital on Staten Island has a great number of training affiliations with institutions on the Island as well as elsewhere in and out of the New York area. The largest of these affiliations is with City University of New York education system, within which there are two colleges on Staten Island—Staten Island Community College and Richmond College. Programs at these schools which affiliate with the PHS Hospital include Associate Degree Nursing, Medical Technology, Laboratory Assistant, and Medical Transcriber. Nearly 400 students are enrolled in these programs. Although there are other hospital affiliations, both on and off Staten Island, the PHS is the mainstay. A program is under development to train Orthopedic Assistants under a grant from the Department of Labor.

Plans are underway to expand the Environmental Health Program of the Richmond College. There are currently 28 students and 27 additional students are planned.

The PHS Hospital is the only hospital in the Northeast participating in the Medical Technician/Clinical Lab Assistant Programs and, with the hospital's accreditation from the American Society of Clinical Pathologists, the Medical Technicians graduating from the program may be registered with the Society for employment consideration nationwide.

Wagner College on Staten Island has an affiliation with PHS, providing training in its Baccalaureate Nursing Degree Program (180 students) and programs in Medical Technology, Bacteriology and Public Health. In these latter programs there are about 8 students each year. The nursing program is concerned a great deal with specialty training in pediatrics and obstetrics, and it is extremely difficult to find other affiliations in such specialty areas. The college mentioned the JCAH high appraisal of the hospital for its clinical programs, facilities, and management. Wagner felt it could not replace the quality level of programs carried on at the hospital. Willowbrook State School (operated by New York State Department of Mental Hygiene) on Staten Island has been an affiliate of the PHS Hospital since 1964 in its School of Practical Nursing. State law prescribes that the nursing affiliation must be with a government or voluntary hospital. This year there are 73 students affiliated at the hospital.

The Marine Assistant Program at the hospital (started in 1966) has already graduated 112 physician assistants for the Merchant Marine and is currently training 32. The physician assistants provide first aid abroad ships and are liaison with PHS physicians on shore through radio contact. The program at the hospital is directed toward the specific needs of the seaman.

Affiliated programs in physical therapy are conducted with Ithaca College, New York University, University of Pennsylvania and University of Wisconsin.

Through the PHS Hospital, the Susan Wagner High School of Staten Island trains potential drop-outs in medical and paramedical careers. 80% of initial enrollees will enter college this fall.

STATEN ISLAND—INTRAMURAL TRAINING

There are currently 59 residents in training at the Public Health Service Hospital. Of these, 13 are completing their last year of residency. The Staten Island Hospital is the only PHS Hospital offering intramural residency training in anesthesiology and dermatology. About 30% of in-service training in the Federal Health Programs Service is provided at the Hospital. Post residency fellowships are offered in cardiology and renology.

Presently, there are 30 interns completing their internships at the hospital.

Other training programs include Nurse Anesthetist (4 employees), Dietary Internship (12 employees) and Radiologic Technology (24 employees).

RESEARCH ACTIVITIES

An exceptionally active and productive intramural research activity has been built at the Staten Island Hospital. It provides an intellectual atmosphere of excellence required to attract and retain key staff, supports and extends the scope of the intern and residency training programs, and creates a base of expertise which is extended to the practicing physicians on Staten Island.

Clinical investigation is currently being undertaken in conjunction with a number of other medical centers in NIH supported cooperative drug studies designed to evaluate the effectiveness of coronary drugs and hypertensive drug therapeutic programs. The intramural program in cardiology is internationally known and has pioneered in the area of cardiac electrophysiology. The renal physiology laboratory is doing pioneering work in membrane physiology, micropunctnre techniques and in additlon runs, for research and teaching purposes, a small renal dialysis unit which provides artificial kidney treatment to beneficiaries and a small number of residents of Staten Island.

ECONOMIC IMPACT AND EMPLOYEE PLACEMENT

Economic impact on Staten Island

The PHS Hospital with over 1,000 employees is the second largest employer on Staten Island. The largest is Procter and Gamble. The third and fourth major employers combined employ almost as many people as the PHS Hospital and have a lower combined payroll.

About 50% of the labor force on Staten Island works on Staten Island. The employees at the PHS Hospital represent 2% of the total work force and about 85% of the hospital employees live on Staten Island.

ECONOMIC IMPACT ON BENEFICIARIES

The increased costs for hospitalization for dependents and retirees through use of OCHAMPUS for hospitalization is a very real economic factor. The Coast Guard expressed concern over the increased cost in their low salaried enlisted personnel who would have to pay *20% of hospital bills.* The retirees under age 65 who pay *25% of hospital costs* under OCHAMPUS out of their fixed income also expressed great concern.

EMPLOYEE PLACEMENT

Early indications are that there would be considerable problems in outplacement. The hospitals on Staten Island say other than a very few positions they are bound by budget constraints and will be unable to absorb our employees. New York City also because of great financial difficulty has recently dismissed 500 employees, 65 of these were in the hospital system. The Veterans' Administration hospitals in the area say that except for a few nurses they will be unable to hire.

POTENTIAL USES OF THE FACILITY

While there may be many uses for the Public Health Service Hospital including use as another general hospital, extended care facility, community health center, geriatric research center, any such plans would have to take into account the various other health construction plans and needs of Staten Island. Participants at the community meeting stated unanimously that such a major decision could be made only after serious deliberations, and that at least 6 months would be required to make a comprehensive review of the situation. In all of these discussions it was stressed by the community representatives that there are no resources in the community, in the city, nor in the state to provide additional support for the facility. In addition, there was serious concern because the hospital structure would not meet the construction codes for state licensure. This would obviate its use as a patient care facility unless costly renovations were made. Additional monies, which are not available, would be required to meet these demands.

The Richmond County Medical Society reported that a proposal was submitted to HEW about 5 weeks ago. This plan suggested that the medical society, medical boards, and voluntary hospitals on the island negotiate to lease between 50–100 hospital beds at the PHS Hospital from the government for use by the community.

In summation, it was the consensus among the participants that additional hospital beds are needed on the island, the community apparently does not have resources to provide additional support for the facility, the expertise and facilities of the hospital are needed and wanted, and the Public Health Service Hospital should be further integrated into the community health requirements.

Mr. ROGERS. If you would furnish for the record the things we have asked for, it would be appreciated, and particularly the letter from the Secretary on the budgetary problems.

Mr. CARDWELL. Yes, sir.

(See letter dated March 19, 1971, on p. 17, this hearing.)

Mr. ROGERS. Are there any further questions?

We appreciate your being here and giving us your testimony. We are hopeful that the Department will give assurances to the Public Health Service people as well as to the beneficiaries about the continuation of these facilities.

Dr. EGEBERG. Thank you very much, Mr. Chairman.

(Whereupon, at 12:25 p.m. the committee was adjourned, to reconvene at 10 a.m. Tuesday, March 9, 1971.)

OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

TUESDAY, MARCH 9, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The committee will come to order, please.

We have two members here. The other will be in very shortly. We are continuing hearings on resolutions expressing the sense of Congress that the public health hospitals and clinics not be closed. We are honored to have a number of members to testify this morning, and first I am very pleased to see the chairman of one of my committees, Merchant Marine and Fisheries Committee, who has done an excellent job in this matter already in holding hearings, and I know that his testimony will be most helpful to the committee. He is vitally concerned with the hospital in Baltimore and he has played a leading role in mounting the fight against the closing of the hospitals.

It is a pleasure for the committee to welcome and to hear the testimony of the Honorable Edward A. Garmatz, Member of Congress from Maryland.

STATEMENT OF HON. EDWARD A. GARMATZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. GARMATZ. I appreciate the opportunity to appear before this subcommittee to give testimony on various concurrent resolutions and related measures which express the sense of Congress with respect to the proposed closing of the eight Public Health Service hospitals and the 30 out-patient clinics. These hospitals and out-patient clinics have provided excellent medical care and attention over the years to the merchant seamen, Coast Guard personnel, Coast and Geodetic Survey employees, U.S. fishermen and other persons who are eligible for these medical services as provided for by Federal legislation. For this reason, I was both surprised and distressed to learn late last fall that the administration was once again considering the shutdown of these necessary Public Health Service facilities.

As you are all aware, this problem is not new and we have been confronted with the proposed closing of these Public Health Service facilities on prior occasions. To be specific, on January 19, 1965, the Secretary of Health, Education, and Welfare announced plans for the closing of Public Health Service hospitals at Chicago, Memphis, Sa-

vannah, Boston, Galveston, Norfolk, and Detroit. In light of our great concern for the welfare of merchant seamen, Coast Guardsmen, and all others entitled to hospital care at these Public Health Service facilities, the Committee on Merchant Marine and Fisheries held six sessions of hearings receiving a broad spectrum of testimony from interested parties and organizations.

In the course of the hearings, questions arose as to the authority of HEW to close any, or all, of these hospitals and to transfer the statutory responsibility of providing hospital care to another government agency. Also, the question arose as to the authority of the Veterans Administration to render care to Public Health Service beneficiaries in preference to veterans of any category. The committee asked the Comptroller General for an opinion on these issues. The Comptroller General's opinion stated that HEW did not have the legal authority to close these hospitals and transfer its statutory responsibility to another government agency and that the VA did not have legal authority to place non-veterans ahead of veterans in priority for admission to VA hospitals. In view of these hearings, the committee's recommendations, and the opinions of the Comptroller General, the Secretary of Health, Education, and Welfare, on July 6, 1965, advised the committee that the planned closing of the Public Health Service hospitals had been re-evaluated and that some of the hospitals would be continued in service and modernized.

Unfortunately, contrary to the committee's confident expectations, this was not the end of the problem. Last fall, it became apparent that the present administration was considering closing the eight U.S. Public Health Service hospitals and the 30 out-patient clinics. As on the prior occasion, this proposal evoked a storm of opposition. I and the members of my committee are gravely concerned over the proposal to close these vital health facilities. Because of this concern, the Committee on Merchant Marine and Fisheries held hearings on this critical problem on December 22 and 30, 1970. I might say that we are very happy to have the chairman of the subcommittee, Mr. Rogers, as a member of our Merchant Marine and Fisheries Committee and he is one of our outstanding members.

At the first hearing, we heard various industry witnesses. At the second hearing, we had testimony from the appropriate officials of HEW, including Secretary Richardson. The Secretary indicated at that time that the administration had not reached any firm decision with respect to this matter. I might say here, Mr. Chairman, there were quite a few questions asked of Secretary Richardson that he could not answer. Two days later I was informed that he was sending out teams to the various hospitals to get the necessary information that was important to answer the questions that we had asked.

It seemed to me as though the Secretary had just arbitrarily closed the hospitals and then sent teams out to find out why he had closed them, a case of putting the cart before the horse. We have not received as yet the report of those teams.

In the President's budget, however, it is stated that with respect to the beneficiaries of these facilities, medical care will be funded for American merchant seamen, PHS Commissioned Corps personnel, and other beneficiaries:

The budget places emphasis on the use of service agreements with private and Federal sources for such care and the conversion of the existing facilities to community use.

It is noteworthy that the budget shows a drop in PHS permanent positions from 6,271 for 1970, and 6,242 for 1971 to only 970 employees estimated for 1972. This reflects a decrease of 5,270 employees from the number presently employed. This very substantial decrease in the number of employees shows clearly the intent to close down these hospitals since these facilities could not possibly continue to operate at the greatly reduced level of 970 employees budgeted for 1972.

In view of this budgetary statement and the apparent disposition of the administration to close these facilities, I solicited all the Members of Congress to join with me in sponsoring a concurrent resolution expressing it to be the sense of the Congress that these hospitals and clinics not only remain open and funds be made available for their continued operation, but that additional funds be made available for the modernizing, upgrading and expansion of these existing facilities so that the Public Health Service may provide optimum medical care and treatment to the eligible beneficiaries.

I secured 194 cosponsors for this resolution. Because of the House Rules which permit only 24 cosponsors on a resolution, eight other identical resolutions were introduced simultaneously with my resolution on February 10, 1971.

On the same day as the introduction of the concurrent resolution, February 10, 1971, I also sent a letter to President Nixon setting out my strong views on this matter and pointing out to him that we had introduced nine concurrent resolutions with some 194 congressional sponsors. I asked him to take cognizance of these resolutions and to continue the Public Health Service hospitals and clinics in operation in accordance with the express will of the Congress.

On February 11, 1971, HEW Secretary, Elliott L. Richardson, announced the formation of an eight-member committee of distinguished citizens to examine the long-range mission, purpose and future of the Commissioned Corps of the U.S. Public Health Service. The chairman of this committee is John A. Perkins who was Under Secretary of HEW in 1957.

A legal opinion dated January 21, 1971, of the General Counsel of HEW held, in effect, that the Department had legal authority to close the Nation's Public Health Service hospitals and clinics. After receiving this opinion, I referred it to Comptroller General Elmer B. Staats asking whether he agreed with the views contained therein, pointing out that his predecessor in office, Joseph Campbell, held, in a decision dated June 7, 1965, that no such discretionary authority existed with the Secretary of Health, Education, and Welfare.

On February 23, 1971, I received an eight-page legal opinion from the Comptroller General which indicated, among other things, that the Department of Health, Education, and Welfare does not have the authority to close all the Nation's Public Health Service hospitals.

Mr. Staats referred to the prior decision of his predecessor and said:

We find nothing in the HEW memorandum that would persuade us to reach a contrary view at this time. The essential thrust of the HEW memorandum is to the effect that the early statutory authority to which the PHS hospital system owes its existence intended contractual arrangements to be the primary

basis for seamen medical care, and that the building and continued maintenance of a Federal hospital system was not contemplated.

We cannot agree that such a system was not contemplated.

The Comptroller General traced the legislative history of PHS hospitals, dating back to 1798, quoting from congressional debates in the 5th Congress (1797–99). He concluded:

The legislative history of the 1798 Act indicates clearly that the construction of a marine hospital system was contemplated. . . .

The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since the passage of the 1798 Act, and on the basis of this Act numerous hospitals were constructed and maintained throughout the country during the 19th and 20th centuries.

Today, under the Public Health Service Act of 1944, 42 U.S.C. 201 et seq., the statutory basis for the continued maintenance of the PHS hospital system, in our opinion remains.

We find no provision in the Act, which authorizes the Secretary to close down the entire PHS hospital system by means of the sale or lease of all Service institutions, or by means of the utilization of contractual medical care arrangements.

The Comptroller General clarified his predecessor's 1965 decision with respect to the authority of the Public Health Service to refer beneficiaries, at the expense of the Service, to public or private hospitals. In this connection, he said that the legislative history makes clear that this provision is designed to meet overflow conditions and cases where beneficiaries may be removed from any service facilities. In other words, the referral authority is to be used in these limited circumstances.

Since decisions of the Comptroller General are conclusive and binding on the executive branch of the Government, it would seem that this ruling by Mr. Staats would put an end to the doubts and concern regarding the future of these important Public Health Service facilities.

It was surprising to me to learn that at hearings before this committee last Friday, Mr. Cardwell of the Department of Health, Education, and Welfare took the position that as between the General Counsel of HEW and the Comptroller General there was merely a difference of opinion of two lawyers. He even remarked he was not sure the Comptroller General was a lawyer. This illustrates a complete lack of knowledge on the part of Mr. Cardwell of the nature and function of the Comptroller General and the General Accounting Office. His authority to render opinions which are binding upon the executive branch has been upheld by the Supreme Court of the United States. I refer him to the case of *Miguel* vs. *McCarl, Comptroller General, et al* (291 U.S. 442, March 5, 1934).

In light of these recent events, I would hope that the administration will now do what it should have done in the first place, and that is to plan immediately to improve and expand these invaluable Public Health Service facilities. I intend to keep a close watch on all developments in this area until I am completely satisfied that the Department of Health, Education, and Welfare does not intend closing these facilities and does intend to continue them in operation in an expanded and vigorous fashion.

I thank the subcommittee again for this time to appear before it and I would like all the members present to know that I stand ready

to help in any way that I can to assure that these necessary facilities are not impaired, but continued.

In that connection, I want to assure the subcommittee that our transcripts of hearings, and in fact all our records, are available to you and your staff for such assistance as they may afford.

Thank you.

Mr. ROGERS. Thank you. I might say that wo do appreciate the fine cooperation that you have extended to the committee. It has been most helpful in getting the information that you already established in the record before the House Merchant Marine and Fisheries Committee, and we are making use of it. They have finally turned over to us the reports of the teams that were sent out, and I think it is interesting to note that nowhere in that report do they recommend the closing of any hospital or clinic. So it is pretty much what we thought, and this is true.

I think at this point, without objection, we will make the letter to you from Mr. Staats, the Comptroller General of the United States, a part of the record.

(The letter referred to follows:)

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., February 23, 1971.

B-156510.

Hon. EDWARD A. GARMATZ,
Chairman, Committee on Merchant Marine and Fisheries, House of Representatives.

DEAR MR. CHAIRMAN: Reference is made to your letter of January 25, 1971, directing our attention to a legal memorandum dated January 21, 1971, by the General Counsel of the Department of Health, Education, and Welfare which concludes that HEW does have authority to close existing public health service hospitals and clinics throughout the country. You cite our letter of June 7, 1965, to the Chairman, Committee on Merchant Marine and Fisheries, holding to the contrary, and ask our current views on this and the other questions posed and answered in the HEW memorandum.

The questions considered in the HEW memorandum are stated as follows:

"1. Does the Secretary of Health, Education, and Welfare have the authority to transfer PHS hospitals and out-patient clinics to non-federal owners?

"2. Does the Secretary of Health, Education, and Welfare have the authority to provide for the care of Public Health Service (PHS) beneficiaries at facilities other than these operated by the PHS?

"3. Can PHS beneficiaries be given priority in Veterans Administration (VA) hospitals ahead of veterans with non-service-connected disabilities?

"4. Can VA and PHS make cross-servicing arrangements to provide for the care of each other's beneficiaries?"

1. *Authority to Transfer PHS Facilities to Non-Federal Owners (Closing of PHS Hospitals).*—In our decision of June 7, 1965, holding that the closing of *all* Public Health Service general hospitals was beyond the discretionary authority of the Department, we stated:

"The Surgeon General, who administers the Public Health Service, is empowered by the Public Health Service Act to 'control, manage, and operate all institutions, hospitals, and stations of the Service * * *' (sec. 248(e)). Our examination of the act does not disclose a substantive basis for restrictively construing the general administrative powers thus conferred. Rather, in the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to out-patient clinics one or more of the Service's general hospitals. The closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority."

We find nothing in the HEW memorandum that would persuade us to reach a contrary view at this time. The essential thrust of the HEW memorandum is to the effect that the early statutory authority to which the PHS hospital system owes its existence intended contractual arrangements to be the primary basis for seamen medical care, and that the building and continued maintenance of a Federal hospital system was not contemplated. We cannot agree that such a system was not contemplated.

The PHS hospital Service traces its origin to the act of July 16, 1798, for the relief of sick and disabled seamen, 1 Stat. 605, which provided authority to the President to (1) receive donations of buildings or land upon which hospital buildings could be erected (section 4), (2) to erect hospital buildings specifically for the care of sick and disabled American seamen (sections 3 and 4), and (3) to appoint Directors of the "marine hospital of the United States" (section 5).

The legislative history of the 1798 act indicates clearly that the construction of a marine hospital system was contemplated. One of the principal grounds of congressional opposition to the bill was the fear that costs of the hospital system authorized to be constructed would outweigh the benefits to be derived from such a system. See *Annals of Congress*, 5th Congress, 1797–1799, Vol. II pp. 1386–1392, containing the following remarks excerpted from the house debate on the bill:

"Mr. Sewall said * * * the tax will fall upon no member of this House, but will be exclusively drawn from the earnings of a small part of the community, who, in all probability, will receive no advantages from it for fifty years to come as large and splendid buildings must first be erected, in order to exhibit to the world a specimen of public charity. (*Id.* p. 1386.)

"Mr. Pinckney was sorry to differ from his friend from Massachusetts * * *. Relief to distress is the first thing to be attended to, and if after affording this relief, the tax produces a sufficient surplus, it is to be employed in the erection of suitable, not large and splendid—buildings, as hospitals. (*Id.* p. 1387.)

"Besides, said Mr. S., this bill proposes the erection of public hospitals * * *. (*Id.* p. 1389.)

"Mr. Gallatin said * * * [i]nstitutions of the kind recommended in this bill might be used in other countries * * *. How far marine hospitals had been useful in Europe he could not tell; he knew there were many rotten public institutions of hospitals, etc., there * * *. There was one part of the bill which he said he could not consent to vote for, viz: That part which directs the erection of buildings, as he was convinced that persons of every description may be better relieved by being dispersed through the country, than by being placed in a hospital." (*Id.* p. 1392.)

Also worth noting are the numerous references throughout the congressional record describing the bill as one providing for the support or erection of marine hospitals. See *id.* p. 1345, 1383, 1386.

The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since the passage of the 1798 act, and, on the basis of this act numerous hospitals were constructed and maintained throughout the country during the 19th and 20th centuries.

In 1861, Secretary of the Treasury Chase found that the number of marine hospitals "has been increased far beyond necessity or utility." Secretary of Treasury, Annual Report, 1861, p. 27. Subsequently, as noted in the HEW memorandum, the Secretary was authorized under the act of April 20, 1866, Revised Statutes, as amended June 27, 1866, section 4806, to sell or lease such marine hospital buildings and lands as he deemed advisable. Most important to note, however, is the fact that Congress in giving such authority insured that the basic hospital system would be maintained by prohibiting the sale or lease of the hospitals at Portland, Maine, and Cleveland, Ohio, and provided that no hospital would be sold or leased if the relief furnished amounted to twenty cases a day. Moreover, only a few years later Congress passed the act of June 29, 1870, 16 Stat. 169, providing for a central administrative agency for the Marine Hospital Service and for the appointment of a supervising surgeon who was to supervise "all matters connected with the Marine Hospital Service," thereby making clear its intent that the hospital system continue to be maintained.

Today, under the Public Health Service Act of 1944, 42 U.S.C. 201 *et seq.*, the statutory basis for the continued maintenance of the PHS hospital system, in our opinion, remains. We agree with the view expressed in the HEW memorandum that the Congress in enacting the 1944 act assumed that the then existing PHS facilities would continue to be utilized, and thus maintained. (See page 7.)

A reading of the act shows it to be replete with references to the PHS hospital system and that a major portion of that law's provisions would he inoperable absent such a system. In reaching this conclusion, we are in agreement with a legal opinion prepared by Assistant General Counsel E. J. Rourke, Department of HEW dated December 17, 1963, and published in the 1965 Hearings on the proposed closing of PHS Hospitals before the Committee on Government Operations. In relevant part, the opinion states as follows:

"As indicated below, this conclusion rests in part upon a specific provision in the Public Health Service Act and more broadly on a variety of indications in that act that Congress intends the PHS to operate its own medical facilities. We do not think this intention is substantively qualified by the fact that provision is also made in the Public Service Health Act for the Service to obtain care for certain of its beneficiaries at other public or private facilities at Service expense.

"We may begin with the obligation of the Surgeon General to care for seamen and the other listed beneficiaries 'at hospitals and other stations of the Service' (Public Health Service Act, sec. 322(a)). We know of no reasonable way to read this provision except as imposing an obligation ou the Surgeon General to establish and maintain medical facilities of the Service for the care of those who by statute are entitled to it. This literal reading of the provision is the only one in accord with the long history of the Marine Hospital Service which began in 1798 with an authority to construct hospitals specifically for the seaman beneficiary. The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since.

"There are other provisions of the Public Health Service Act which are not operable in the absence of Service hospitals, institutions and stations. Thus the authority to admit and treat for purposes of study persons not otherwise eligible is an authority that can be exercised only at institutions, hospitals and stations of the Service (sec. 301(f)). Also, the authority to provide medical, surgical, and hospital services to BEC beneficiaries can be exercised only at institutions, hospitals, and stations of the Service (sec. 324). Finally, the authority to provide for narcotic addicts may he exercised only at hospitals of the Service (sec. 341). While these provisions do not require the exercise of the authority conferred, it seems obvious that Congress intended the authority to be exercised in appropriate situations; to this extent, appropriate medical facilities of the Service are required.

"Finally, there are other statutory provisions that certainly contemplate the operation of an appropriate PHS hospital system. Examples are the Surgeon General's authority to manage and operate hospitals and to establish new ones (sec. 321), the authority to care for certain persons at hospitals of the Service where detained by Immigration authority (sec. 502), and the authority to admit into any hospital, institution, or station of the Service insane persons entitled to Service treatment (sec. 504).

"*We would thus conclude that there is no question but that the Public Health Service Act represents the congressional intent that a hospital system be operated and maintained by the Service to carry out the obligations imposed by or implicit in the several statutory provisions noted.* (Emphasis added.)

"The fact that legal authority is given to the Service under section 322(e) to procure care at other than its own facilities in the case of specified beneficiaries, in our view does not reflect a congressional intention to offer the Service an alternative to the operation of its own hospital system. Rather this is a supplemental authority designed to assure prompt and adequate medical care to selected beneficiaries where Service facilities are not available. This conclusion is clearly supported first by the terms of the act which call for authorization by the medical officer in charge on application—an individualized determination. It is also supported by the legislative history of section 322(e).

"Thus in codifying the statutes relating to PHS in 1944, the significant committee report, that of the House, stated with respect to this subsection:

" 'Subsection (e) would authorize treatment of Service beneficiaries in other hospitals, at the expense of the Service, as provided in regulations. This provision, which would afford a statutory basis for present regulations, is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility.' "

As indicated in Mr. Rourke's opinion, 42 U.S.C. 248(a) charges the Secretary with the management and operation of "all institutions, hospitals, and stations

of the service" (emphasis added), and authorizes the Secretary, with Presidential approval, to "select sites for and establish institutions, hospitals, and stations" as deemed necessary. We find no provision in the act which authorizes the Secretary to close down the entire PHS hospital system by means of the sale or lease of all Service institutions, or by means of the utilization of contractual medical care arrangements.

With respect to the argument raised by the Department that the Federal Property and Administrative Services Act of 1949 authorizes the Secretary to transfer all hospital facilities to nonfederal ownership should he find such properties to be excess to the needs of the Department, we cannot agree.

"Excess property" is defined in the act, 40 U.S.C. 472(e), as property of a Federal agency "not required for its needs and the discharge of its responsibilities, as determined by the head thereof." We find nothing in the legislative history of the Federal Property and Administrative Services Act to suggest that the Congress intended the authority to dispose of excess property to be used by a Federal agency as a means of relieving itself of its statutory responsibilities. In our view, the utilization of such act as a vehicle for closing down the entire PHS medical facility system, and thereby effectively terminating the hospital medical care role performed by the PHS for the past 170 years, would be wholly inappropriate. Such action would relieve the agency of the function of maintaining a hospital system which, as we have shown above, has heretofore been considered by the Congress to be an essential statutory responsibility.

It is therefore our opinion that under the 1944 Public Health Service Act, the Congress intended that the hospital system characteristic of the Service since its inception in 1802 with the Marine Hospital is to be operated and maintained by the Service in order to carry out the functions and duties imposed by the 1944 act. In light of the foregoing, the Secretary may not, in our view, use his discretionary powers under the 1944 Public Health Service Act or the Federal Property and Administrative Services Act of 1949 to effect the closing of *all* PHS hospital facilities by means of the transfer of these institutions to nonfederal ownership.

2. *Authority to Provide for Care of PHS Beneficiaries in other than PHS Facilities.*—Consistent with the foregoing, we stated in our June 7, 1965, decision that the Public Health Service Act "in the absence of Public Health Service facilities authorizes the referral of such beneficiaries, at the expense of the Service, to public or private hospitals (42 U.S.C. 249)." As pointed out above, the legislative history makes clear that this provision is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility. 78th Congress, House Rept. 1364, April 28, 1944, on H.R. 4524. Accordingly, we would see no legal objection to the referral of PHS beneficiaries to other public or private facilities, under such limited circumstances.

3, 4. *Priority of PHS Beneficiaries in VA Hospitals and Authority to Arrange for Cross-servicing of VA and PHS Beneficiaries.*—Regarding the priority of PHS beneficiaries in VA hospitals, we stated in a letter dated June 22, 1965, copy enclosed, to Chairman Fountain, Intergovernmental Relations Subcommittee, House Committee on Government Operations, that the rendering of a service by an agency under section 601 of the Economy Act of 1932, 31 U.S.C. 686, which authorizes Federal departments and agencies to place orders for goods and services with other Federal agencies, if it can be considered a function of the agency rendering the service, is at best a secondary or incidental function, and that section 601 certainly was not intended to be a basis for transferring a primary administrative function from an agency in which it is vested by Congress.

Since by statute the primary function of the PHS is to provide care for seamen and that of the VA to provide care for veterans, we could not then, and do not now, see a legal basis for admitting merchant seamen to VA hospitals ahead of veterans eligible for treatment of nonservice-connected disabilities.

Regarding the authority to arrange for cross-servicing of VA and PHS beneficiaries, we stated in our June 22, 1965, letter that the admission of merchant seaman to VA hospitals would involve interagency services under 31 U.S.C. 686, since merchant seamen are not beneficiaries of the Veterans Administration, and that "except as a humanitarian service in emergency cases," the Administrator of Veterans Affairs would otherwise not be authorized to admit merchant seamen. See 38 U.S.C. 610, 611. Accordingly, and provided that the VA is "in a position to supply or equipped to render" the services requisitioned in accord-

ance with the requirements of section 601 of the Economy Act, we see no legal objection to periodic arrangements for cross-servicing of VA and PHS beneficiaries.

We trust that the above is responsive to your request.

Sincerely yours,

(Signed) ELMER B. STAATS,
Comptroller General of the United States.

Enclosure.[1]

Mr. ROGERS. And also the memorandum from Mr. Hastings, general counsel of HEW, stating their position will be made a part of the record at this point, too.

(The memorandum referred to follows:)

[Memorandum]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
OFFICE OF THE GENERAL COUNSEL,
Washington, D.C., January 21, 1971.

To: The Secretary.
Through: OS/ES.
From: Wilmot R. Hastings, General Counsel.
Subject: Medical Care for Public Health Service Beneficiaries—Information Memorandum.

ISSUES

In connection with a request for additional information made by the House Committee on Merchant Marine and Fisheries on December 30, 1970, you have asked us to provide you with both a legal opinion on certain questions and a comment on a Comptroller General opinion dated June 7, 1965, regarding those questions. The questions are:

1. Does the Secretary of Health, Education, and Welfare have the authority to provide for the care of Public Health Service (PHS) beneficiaries at facilities other than those operated by the PHS?

2. Does the Secretary of Health, Education, and Welfare have the authority to transfer PHS hospitals and out-patient clinics to non-federal owners?

3. Can PHS beneficiaries be given priority in Veterans Administration (VA) hospitals ahead of veterans with non-service-connected disabilities?

4. Can VA and PHS make cross-servicing arrangements to provide for the care of each other's beneficiaries?

Authority to Provide for Care of PHS Beneficiaries in Other Than PHS Facilities

The Congress has long recognized that utilization of non-federal facilities would be required to provide medical services needed by beneficiaries of the PHS. Indeed, the Act of July 16, 1798,[1a] which established the foundation for the marine hospitals, directed the President, from funds made available for this purpose, "to provide for the temporary relief and maintenance of sick or disabled seamen, *in hospitals or other proper institutions now established in the several ports of the United States* . . ." (Emphasis added.) He was further authorized, from any surplus of such funds, "to cause buildings, *when necessary*, to be erected as hospitals for the accommodation of sick and disabled seamen." (Emphasis added.)

The program for the medical care of seamen was thus begun on the basis of contract care, and, although federal hospitals were thereafter constructed as and when believed necessary, contract care has constituted an inherent element of the program since its inception. The current provision specifically authorizing contract care and treatment for specified beneficiaries of the Service (including seamen) is contained in section 321(e).[2] The use of this authority is not limited by, and is not in any way dependent on, the existence of federal hospitals.

The Comptroller General clearly concurred in this opinion. In his letter of June 7, 1965, he stated:

[1] Enclosure not printed.
[1a] 1 Stat. 605.
[2] As to other PHS beneficiaries entitled to care, adequate authority appears to exist for the provision of care by a variety of appropriate arrangements. See 42 U.S.C. §§ 248(b), 253, 254; E.O. No. 11160, 29 F.R. 9315.

The Public Health Service Act . . . in the absence of Public Health Service facilities authorizes the referral of . . . beneficiaries, at the expense of the Service, to public or private hospitals . . .[3]

Authority to Transfer PHS Facilities to Non-Federal Owners

We find no provision in the Public Health Service Act (42 U.S.C. 301 et seq.) which addresses directly the question of the authority of the Secretary to transfer or otherwise dispose of PHS facilities. The Act does provide, however, that the Surgeon General[4] shall "control, manage and operate all institutions, hospitals, and stations of the Service" (42 U.S.C. 248(a)), but it does not specify the number or kind of facilities to be operated or the locations at which they are to be operated. There is no question of the legal authority of the Secretary to close one or more general hospitals as, in the exercise or his judgment, seems desirable to him.[5]

The view has been expressed, however, that such authority does not extend to closing *all* the general hospitals. The Comptroller General states in his letter that while the closing of selected hospitals was a matter "involving professional judgment" and within the discretionary authority of the Surgeon General, "the closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would, in our opinion, be an unwarranted extension of the Surgeon General's discretionary authority."

A similiar observation was also made by a former General Counsel of the Department of Health, Education, and Welfare in a letter dated April 17, 1965, which stated, in part:

"We believe that the Public Health Service Act does require the Surgeon General to operate hospitals for the care of certain beneficiaries (Sec. 322(a)). But we think it quite clear that nowhere does the statute specify or otherwise require any given number, size, or location of such hospitals. *As long as a hospital system is maintained*, the question of the extent to which any given facilities are required rests in the sound discretion of the Surgeon General." (Emphasis added.)

We are unable to find any specific support in the Public Health Service Act or its predecessor statutes for these observations.[6] Our research has failed to disclose any Congressional mandate requiring the maintenance of a "hospital system" or any specific number of hospitals for the provision of care to seamen or other beneficiaries of the Service under the Public Health Service Act, so long as the required medical services may be provided by other authorized means.

As already pointed out, the seamen's medical care program had its genesis in contract care arrangements, and until the middle of the nineteenth century most of the services provided by the marine hospital fund were through contract with local hospitals, private physicians and boarding houses.[7] Of the 31 hospitals which were established between 1798 and 1870, only nine were in use for the accommodation of sick and disabled seamen in 1872,[8] and some of these had no patients.[9]

In response to a request for authority to dispose of unneeded buildings,[10] Congress enacted legislation, which, as codified in Section 4806 of the Revised Statutes, 1875, authorized the Secretary of the Treasury (when then had responsibility for the Marine Hospital Service) to lease or to sell at public auction "such marine hospital buildings and lands appertaining thereto as he may deem it ad-

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[3] Opinion of the Comptroller General, June 7, 1965, H.R. Report No. 610, 89th Cong., 1st Session, p. 22.

[4] Under section 1 of Reorganization Plan No. 3 of 1966, all functions of the Surgeon General were transferred to the Secretary.

[5] Opinion, *op. cit.* fn. 3, p. 22.

[6] It should be noted that the Comptroller General was not asked to respond to the same questions that were raised by the Committee on December 30, 1970. Specifically, the Comptroller General was attempting to deal with a proposed transfer of statutory responsibility for PHS beneficiaries and some hospitals in connection with a proposed plan of executive action significantly different from the proposals which are now under consideration. See Opinion of the Comptroller General, *op. cit.* note 3.

[7] Robert Strauss, *Medical Care for Seamen.* (1950) p. 41, citing the report of the Secretary of the Navy, 1882. "The Marine Hospital Service of the United States."

[8] Strauss, *op. cit.* p. 57.

[9] Ibid, p. 71, citing U.S. Marine Hospital Service, *Annual Report,* 1873.

[10] Ibid, p. 68.

visable to sell."[11] Far from mandating a "hospital system", this statnte emphasized that, except for the hospitals in Cleveland and Portland, all the other hospitals of the Service conld be closed if the daily patient case load and the contract care requirements of the statnte were met.[12]

In enacting the Public Health Service Act of 1944, which repealed R.S. 4806, Congress did not deal with the question of the disposal of PHS facilities. There is no discussion of this issue in either the House or Senate reports on the Act[13] nor is there any section corresponding to the earlier R.S. 4806 cited previously.

Because the Public Health Service Act does not address this questiou directly in any manner, we must look to other sources for the authority in question. The Constitution of the United States, of course, places in the Executive Branch the authority "to take care that the laws are falthfully executed.[14] The executive power has been clearly established as a broad responsibility to administer the government in a responsible manner consistent with the policies expressed by Congress.[15] We view the principal thrust of § 249 *et seq* of Title 42 as providing for the medical needs of PHS beneficiaries. The purpose to these provisions is to assure that care is provided, not to assure that there be facilities for the Secretary to manage under § 248. A decision by the Secretary to provide for the medical care of PHS beneficiaries as required by the Congressional policy expressed in the Public Health Service Act in a manner other than through the maintenance of facilities owned and operated by the PHS would appear—other things being equal—to be within the scope of that executive power.

In addition to the broad mandate of executive power contained in the Constitution, the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 471 *et seq*) establishes as Congressional policy the economical and efficient utilization of government property (40 U.S.C. 471) and places an affirmative responsibility on the executive agencies such as the Department of Health, Education, and Welfare to take various actions to assure maximum utilization of government property. Specifically, section 202 of the Act requires the Department to: "Continuously survey property under its control to determine which is excess property . . . and transfer or dispose of such property as promptly as possible in accordance with the authority delegated and regulations prescribed by the Administrator." (10 U.S.C. 483(b))

Thus, the Secretary not only has the authority, but also the duty to review the utility of all HEW facilities and to transfer those facilities to other ownership if he finds they are excess to the needs of the Department. We know of no exception to this general duty for PHS facilities. Should the Secretary find that the Congressional mandate to economically and efficiently utilize government property is not being met by the present method of delivering health care to PHS beneficiaries primarily through facilities owned and operated by the PHS, he would appear to have a responsibility to alter that method of delivery, in the absence of some clearly conflicting Congressional mandate.

As discussed earlier, we are unable to find any such contrary mandate expressly set forth in the Public Health Service Act. In reviewing the present statutory framework for the delivery of health care to PHS beneficiaries, it seems fair to conclude that the Congress in the 1944 revision of the Public Health Service Act tacitly assumed that the then existing PHS facilities would continue to be utilized in order to render the necessary services. But in light of the prior statutory scheme and the mandate of the Federal Property and Administrative Services Act of 1949, we cannot infer from this apparent Congressional assumption an overriding requirement that facilities be maintained which, in the judgment of the Secretary, are not needed for the provision of medical care to seamen and other beneficiaries of the Service. Certainly,

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[11] The statute went on to say:

> But the hospitals at Cleveland in Ohio, and Portland in Maine, shall not be sold or leased and this section shall not be construed to authorize the Secretary of the Treasury to lease or sell any such hospital where the relief furnished to sick mariners shall show an extent of relief equal to twenty cases a day on an average for the last preceding four years, or where no other suitable and sufficient hospital accommodations can be produced upon reasonable terms for the comfort and convenience of the patients.

[12] In fact, the Cleveland hospital was closed in 1953 and the Portland hospital in 1952 after the enactment of P.L. 78-410 (The Public Health Service Act of 1944), which repealed R.S. 4806, discussed *infra*.

[13] H.R. Report No. 1364, 78th Cong. 2nd Session and S. Report No. 1027, 78th Cong. 2nd Session.

[14] Art. II, Sec. 3.

[15] See *Myers* v. *United States*, 272 U.S. 52 (1926).

such a contrary mandate cannot be derived from the Secretary's general authority in 42 U.S.C. § 248 to manage those facilities which are so needed.

It is our conclusion, then, that the Secretary not only has the authority, but also the duty to transfer PHS facilities to other ownership, if he finds them excess to the Department's needs to provide the care required by the Public Health Service Act.

Priority of PHS Beneficiaries in Veterans Administration hospitals

In connection with the question of the relative priorities in the admission to Veterans Administration hospitals of Public Health Service beneficiaries and veterans with non-service-connected disabilities, the Comptroller General in his opinion of June 22, 1965, to the then Chairman of the House Committee on Government Operations stated:

We perceive no legal basis for admitting merchant seamen to Veterans Administration hospitals ahead of veterans eligible for treatment of non-service-connected disabilities.[16]

Since the question of such priority is a matter primarily for determination by the Veterans Administration, we would defer to their views on the question.

Authority to Arrange for Cross-Servicing of VA and PHS Beneficiaries

With respect to the utilization of Public Health Service hospitals on a reimbursable basis by the Veterans Administration and vice versa under the Economy Act (31 U.S.C. 686), we see, in general terms, no legal objection to arrangements for such utilization provided, of course, the statutory requirement that the Service is "in a position to supply or equipped to render the desired services" is met.

Mr. GARMATZ. I am most happy that these documents will be included in the record, and I am sure that the members of the Merchant Marine and Fisheries Committee are in accord with the purposes of these hearings. We recognize that this matter comes under the jurisdiction of your subcommittee. The Merchant Marine and Fisheries Subcommittee is greatly interested in these beneficiaries, and that was the reason for our taking the lead in this matter. We are happy to see that you are going to carry on and we are anxious to cooperate in every possible way.

Mr. ROGERS. We certainly will work closely with you and we appreciate all of the help you can give us.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman, for your testimony and coming from the chairman of the Merchant Marine and Fisheries Committee, it is certainly entitled to great weight. I would say you have indeed kept a close watch on all developments in this area and everyone concerned with it should be grateful to you.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Schmitz?

Mr. SCHMITZ. No questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. No questions.

Mr. ROGERS. Thank you very much. We are grateful for your testimony this morning.

Mr. ROGERS. Our distinguished colleague, the Honorable Brock Adams, who is a member of the full committee, from the State of Washington, has been interested in this from the beginning and has been very helpful and in fact he has been trying to gather the information necessary to mount an attack upon the closing of the hospitals.

We are delighted to welcome you to the committee and will be pleased to receive your testimony.

[16] Opinion of the Comptroller General, June 22, 1965, H.R. Report No. 544, 89th Cong., 1st Session, p. 51.

STATEMENT OF HON. BROCK ADAMS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. ADAMS. Thank you, Mr. Chairman. I appreciate very much the opportunity to testify. I know that the chairman is a member of the Merchant Marine and Fisheries Committee and a member of us attended the hearings at that time in December. The purpose of my testimony this morning is to update the situation as we know it from Seattle, which has one of the facilities, and to comment on Dr. Egeberg's testimony which took place Friday before this committee.

I would ask permisson that my statement might be inserted in the record so that my testimony will not be repetitive to what Chairman Garmatz has given to the committee, and will go directly to the points that are involved.

Mr. ROGERS. Yes, that will be very helpful and without objection the statement will be made a part of the record at this point, following your verbal statement.

Mr. ADAMS. I will pick up at the second page on my statement. The first part simply reiterates what the chairman said, that our concern arises from the fact that there are no funds in the fiscal year 1972 budget for the operation of these hospitals, and if there are no funds being requested I think we have some reason to believe that these hospitals will not be in existence at that time.

Now, starting on page 2, I am aware that Dr. Egeberg, who is the Assistant Secretary, and Dr. Vernon Wilson testified in Secretary Richardson's absence before this committee on Friday. They carefully avoided the use of the word "closure" and they used the words "conversion" or "transfer". We think this is because HEW hopes this would avoid the strong opposition in Congress to closure. If the administration does not mean "closure," why is there no money in the 1972 budget? If it means transfer why is there no information available on what such a "transfer" will cost?

My information from the University of Washington, which utilizes a significant portion of the Public Health Service hospital in Seattle, is that the cost of contracting care and leasing the building will be considerably higher than the costs to maintain it.

Now, I also understand that Dr. Egeberg testified before the committee that the hospital was only operating at 64.5 percent of capacity.

As far as the Seattle hospital is concerned, this is very misleading, because it is based on the premise that the hospital was funded to 100-percent basis, when in fact it has not been. It has lacked a full nursing force, has been dreadfully short on medical supplies, and it has been denied any funds to buy new or even replacement equipment. The administration seeks to make political mileage out of an underutilization rate which it has caused.

What I am frankly very concerned about as a member of the full committee is that the Department of Health, Education, and Welfare will try to keep the committee in the dark until September or October while it is studying various contract arrangements with medical schools or other community arrangements, and this will then cut off the young interns and residents from being utilized by the hospital because they will have to make their decisions long prior to this. And, second, they will be unavailable at the time when you will need them in the fall.

Now, in the testimony of Dr. Egeberg on Friday, I am informed he emphasized that no negotiations had yet been held with representatives of any community in which the hospitals are located.

It is my information, to the contrary, that a number of medical school deans and vice presidents of universities have been summoned to Washington to meet with Dr. Wilson to discuss contracts for assumption of management of the hospitals, the date of assumption being as early as July 1, 1971.

I want to correct my statement at this point. On page 3, where I say those deans and vice presidents whom Dr. Wilson contacted or met with—in other words, some he has contacted, some he has met with—include representatives of Louisiana State University and Tulane, Johns Hopkins, the University of Washington, University of Texas, Galveston, and a medical school in New York City.

I wonder, Mr. Chairman, how equal the bargaining power is between the administration which is threatening to cut off all money for the Public Health Service hospitals and those medical schools which are dependent on these hospitals for facilities, research laboratories, and specialized equipment. Can it be doubted that the deans and vice presidents are going to be literally forced into these contracts in some form? I am told at least one university has refused to even go into further discussions on the subject.

Now, the current budget for fiscal year 1971, as we know, is $84 million, and this is considered "bare bones." It allows for no new equipment, except in the event of an emergency, and necessitated a large cut in a number of positions, as Chairman Garmatz specifically testified.

We understand HEW is quietly discussing a figure of some $10 to $15 million less for fiscal year 1972, which would allow for treatment of only primary beneficiaries and would exclude Vietnam widows, retired military personnel, and American Indians. This is not "quality medical health care."

It was also indicated at the hearings that the administration intends to turn over the operation of the hospitals and clinics to universities or some other group. Who is going to pay for this operation? I am sure the universities feel they cannot afford to do so. Will the Government then be required to subsidize these operations at a far greater cost?

During the hearings on Friday, Dr. Egeberg and Dr. Wilson, I am informed, made a number of statements which I find either inaccurate or misleading. First, Dr. Egeberg alluded to the fact that community development officials in some of the cities serviced by Public Health Service hospitals had been contacted with regard to other hospitals or groups assuming contracts for operation of the Public Health Service hospitals. The director of the Department of Community Development in Seattle advises me in Seattle at least no such contact has been made.

Second, the statement was made that all Members of Congress whose districts include hospitals or clinics were notified in advance of the on-site visits. I can categorically deny this. Even though I have a hospital in my district and even though I serve as a member of this committee, I was not notified at all by the administration, and my staff had to learn of this from other sources in the community.

Third, Dr. Egeberg specifically mentioned that the University of Washington School of Medicine is definitely interested in taking over the Seattle Public Health hospital. I believe it is more accurate to say that the university is more interested in retaining the excellent training and research facilities of the hospital and would only consider assumption of the hospital if the administration offers the alternative of "closure" and then puts up the money for the transfer.

The closure of the Seattle hospital would be a major disaster for the Pacific Northwest because it provides quality medical care, not only for the State of Washington, but the whole Pacific Northwest and the State of Alaska. It would be a tragic loss for the entire region. And, at the same time, when we have a severe recession, it would also be an economic blow. We do not know where the people would be shifted. At the present time, unemployment runs about 15 percent in our city.

The Seattle Public Health Service hospital has long been an integral part of the school of medicine of the University of Washington. The patients, staff, and facility all represent a substantial and essential contribution to the university's educational program. Now, again I do not want my testimony to be the only basis for this or for it to be secondhand. I have talked and my staff has talked with Dr. Robert Van Citters, dean of the school of medicine, and he advises me that no other Public Health Service hospital has similar affiliation because not only does University of Washington School of Medicine use the facility, but the university schools of dentistry and pharmacy have individual agreements, as do Seattle University School of Nursing, Providence Hospital, Seattle Central Community College, Shoreline Community College, and the Swedish Hospital.

Insofar as University of Washington School of Medicine is concerned, a substantial number of the school's senior faculty is based at the hospital. Its internship and residency programs are totally integrated, so that at any time 20 interns and 30 residents are located at the hospital. Similarly, at any given time 20 percent of the medical students are located at the hospital.

The division of oncology, which is biology of tumor and cancer, utilized approximately 12,000 square feet at the hospital and employs 56 individuals and 14 physicians, all of whom work at the hospital. The university's major cancer research effort is located at the hospital and it is the only facility west of Salt Lake City.

During the hearing it was indicated the Seattle hospital had the patient load. Figures given to me by Dr. Willard Johnson, director of the Seattle Public Health Service hospital, show a higher patient load than was testified to. Actually, it is over 76 percent occupancy. In addition to the large number of seamen, Coast Guard personnel, National Oceanographic and Atmospheric Administration personnel, active duty and retired military personnel and dependents, this hospital treats a significant number of American Indians and Eskimos who live in the service area.

So the committee might have a firsthand report on the hospital I have requested Secretary Richardson to allow Dr. Johnson to testify. As of this time, I have had no response to my request. I have also asked Dean Van Citters the nationally prominent dean of University of Washington School of Medicine to appear, and it is my understanding

he will appear on Thursday to go into details with the committee of what I have just generally touched on.

The logic of the HEW position escapes me, because these facilities play an integral part in our national health care network and I feel the training programs, and the service that is given, through all of these hospitals, are of great importance.

It may be that some hospitals have a 30 percent vacancy rate. There are fewer beds available at the other community hospitals. How are these hospitals going to absorb the patients? And how could the universities afford to operate them?

It makes better sense to me, and I imagine the figures which HEW has been asked to submit will show it, to improve the present facilities and extend the hospitals' authority to utilize the other 30 percent through such avenues as the Emergency Medical Personnel Act of 1970.

Mr. Chairman, I thank you for letting me come and present this testimony. And others from Seattle will be available, as I indicated, but I wanted this committee to know my experience with what has happened and the information that we had about it.

(Mr. Adams' prepared statement follows:)

STATEMENT OF HON. BROCK ADAMS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. Chairman and distinguished members of the subcommittee, I appreciate this opportunity to appear before you. In January following the hearings by the Committee on Merchant Marine and Fisheries I, along with several other members, requested that this subcommittee hold hearings on the subject of closing 8 Public Health Service Hospitals and 30 clinics. As you know, the Administration has requested no funds in Fiscal Year 1972 to keep these hospitals open and this is a pressing issue. I want to express my appreciation to you and the Committee for proceeding so promptly.

I am pleased to testify today in support of House Concurrent Resolution 155 and House Concurrent Resolution 108 of which I am a sponsor, and related legislation. I am unalterably opposed to the closure of the Seattle Public Health Service Hospital and in fact, am equally opposed to the closure of any of the seven other hospitals and 30 outpatient clinics until this Committee, along with the Merchant Marine Committee, has had the opportunity to conduct its own in-depth investigations. I am sure that the Seattle Hospital would welcome an investigation by this Committee and I would respectfully suggest that you consider this suggestion, Mr. Chairman.

I strongly support such Congressional inquiries, Mr. Chairman, because I do not feel that the Nixon Administration and the Department of Health, Education and Welfare have been completely honest with the Congress or the country. While the Administration talks about "quality health care" for the American people, it slashes the entire 84 million dollar budget for all Public Health Hospitals and outpatient clinics. While it talks "better delivery of health services," it also plans to curtail treatment for Vietnam widows, retired military, American Indians and Eskimos.

I am aware that Dr. Roger Egeberg, Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs, and Dr. Vernon Wilson, Administrator of the Health Services and Mental Health Administration, who testified in Secretary Richardson's absence before this Committee on Friday of last week, carefully avoided the word "closure." They used such words as "conversion" or "transfer"—in hopes, perhaps, that the strong opposition in Congress to "closure" will wane. I do not believe that Members of Congress are so easily dissuaded. If the Administration does not mean "closure," why is there no money in the FY 1972 budget for the operation of these hospitals and clinics? And if it really means "transfer" of these facilities to medical schools, why is there no information available on what such a transfer will cost. My information, from the University of Washington and the Seattle Public Health Hospital, is that the costs of contracting care and leasing the building will be higher than present, and probably significantly higher.

I am aware that Dr. Egeberg stated that many of the Public Health Hospitals are under-utilized and that the Seattle facility, in particular, was operating at only 64.5% capacity. As far as the Seattle Hospital is concerned, this statement is misleading. It is based on the premise that the Hospital has been funded on a 100% basis when in fact the Hospital has lacked its full nursing force, has been dreadfully short on medical supplies, and has been denied the funds to buy new or replacement equipment. The Administration seeks to make political mileage out of an under-utilization rate which it has caused.

I am frankly quite concerned that H.E.W. will try to keep this Committee in the dark until September or October while it studies various "contract" arrangements with various medical schools or other community organizations. Is this fair to the hundreds of young doctors who must decide now where to intern or serve their residency? Is this fair to the thousands of staff members of these hospitals and clinics who must decide now whether or not to seek employment elsewhere?

Mr. Chairman, I regret that the Administration has chosen to play politics with the health care of millions of Americans. Because it has, however, it is especially incumbent upon us to demand that the cost and other data upon which H.E.W. will base its future decisions is both sound and totally factual. For that reason, I would hope that Secretary Richardson will come before this Committee—as he was scheduled to do—and answer some very basic questions.

In the testimony of Dr. Egeberg on Friday, he emphasized that no negotiations had yet been held with representatives of any community in which the hospitals are located. It is my information, to the contrary, that a number of medical school Deans and Vice Presidents of universities have been summoned to Washington to meet with Dr. Wilson to discuss contracts for assumption of management of the hospitals, the date of assumption being as early as July 1, 1971. Those deans and vice presidents whom Dr. Wilson has met include representatives of Louisiana State University and Tulane, Johns Hopkins, the University of Washington, University of Texas (Galveston), and a medical school in New York City.

I wonder, Mr. Chairman, how equal the bargaining power is between the Administration, which is threatening to cut off all money for Public Health Hospitals, and those medical schools which are dependent on these hospitals for facilities, research laboratories, and specialized equipment. Can it be doubted that deans and presidents are going to be literally forced into contracts. I am told that at least one university has even refused to have further discussions on this subject.

The current budget for FY 1971 for the hospitals and clinics is $84 million. This is considered to be a "barebones" budget. This figure allows no new equipment except in the event of emergency and necessitated a large cut in the number of positions. Now HEW is quietly discussing a figure some $10 to $15 million less for Fiscal Year 1972 which would allow treatment for only primary beneficiaries and would exclude Vietnam widows, retired military personnel and American Indians. This is not "quality health care."

If, as was indicated at the hearings, the Administration intends to turn over the operation of the hospitals and clinics to Universities or some other group, who is going to pay for the operation? I am sure the Universities feel they can not afford to do so. Will the government then be required to subsidize operations at a far greater cost?

During the hearing on Friday, Dr. Egeberg and Dr. Wilson made a number of statements which I find either inaccurate or misleading. First, Dr. Egeberg alluded to the fact that community development officials in some of the cities serviced by Public Health Hospitals had been contacted with regard to other hospitals or groups assuming contracts for operation of the Public Health Service Hospitals. The Director of the Department of Community Development in Seattle advises me that in Seattle, at least, no such contract was made. Second, the statement was made that all Members of Congress whose districts include hospitals or clinics were notified in advance of the on site visits. I can categorically deny this. Even though I have a hospital in my district, and even though I serve as a Member of this Committee, I was not notified at all by the Administration, and my staff had to learn of this from other sources in the Community. Third, Dr. Egeberg specifically mentioned that the University of Washington School of Medicine is definitely interested in taking over the Seattle Public Health Hospital. I believe it is more accurate to say that the University is more interested in *retaining* the excellent training and research facilities of the Hospital and

would only consider the assumption of the Hospital if the Administration offers the alternative of "closure" and then puts up the money for the transfer.

The closure of the Seattle Hospital would represent a major disaster for the Pacific Northwest. The hospital provides quality medical care to individuals not only in the State of Washington, but throughout the Pacific Northwest and Alaska. Its closing, at a time when the demand for quality health care is so critical, would be a tragic loss to the entire region. The beneficiaries of the hospital would be without appropriate medical care and the area would be dealt another economic blow. This is at a time when, as you know, the economy in Washington State is suffering a severe recession. Seattle has the highest unemployment rate in the country—13% and it is growing. But in addition this would have a serious effect on efforts to supply health manpower for the region.

The Seattle Public Health Service Hospital has long been an integral part of the School of Medicine at the University of Washington; the patients, staff and facilities all represent a substantial and essential contribution to the University's educational program.

Dr. Robert Van citters, Dean of the School of Medicine, advises me that no other PHS hospital has similar affiliations. Not only does the University of Washington School of Medicine use the facility, but the University's Schools of Dentistry and Pharmacy have individual agreements, as do Seattle University's School of Nursing, Providence Hospital, Seattle Central Community College, Shoreline Community College and Swedish Hospital.

In so far as the University's School of Medicine is concerned, a substantial number of the School's senior faculty is based at the hospital; its internship and residency programs are totally integrated so that at any time 20 interns and 30 residents are located at the hospital. Similarly, at any given time, 20% of the medical students are located at the hospital.

The Division of Oncology (that is, the biology of tumors and cancer) utilizes approximately 12,000 feet of the hospital and employs 56 individuals including 14 physicians, all of whom work at the hospital. The University's major cancer research effort is located at the hospital. This is the only facility west of Salt Lake City.

During the course of the hearing it was indicated that the Seattle Hospital had the lowest patient load among the 8 hospitals. Figures given to me by Dr. Willard Johnson, Director, Seattle PHS Hospital, show a higher patient load as well as a higher number of outpatients. If my computations are correct the Seattle Hospital actually has over 76% occupancy.

In addition to a large number of seamen, Coast Guard personnel, National Oceanic and Atmospheric Administration personnel, active duty and retired military personnel and dependents, this hospital treats a significant number of American Indians and Eskimos who live in the service area.

The hospital also provides health services for the community. It is the focal point for treating contagious diseases, it conducts a family planning clinic and operates health care clinics 3 nights a week on a volunteer basis. The hospital also has a research laboratory in endocrinology and reproductive physiology, a research training unit for individuals desiring careers in academic medicine and an infectious disease laboratory.

So that the Committee might have a complete first hand report on the operation of the Seattle facility I have requested Secretary Richardson to allow Dr. Willard Johnson to testify. At this time I have had no response to my request. I have also asked Dean Robert Van Citters, the nationally prominent Dean of the University of Washington School of Medicine, to appear and he will testify on Thursday.

The logic of HEW's several positions escapes me. These facilities play an integral part in our national health care network. Nearly a million Americans currently receive comprehensive health care at these hospitals and clinics. Not only do these hospitals and clinics provide health care for nearly a million of our citizens, but they also provide training for hundreds of physicians and dentists who are serving in internship and residency programs, and for scores of paramedical personnel who are trained at these facilities. I feel these training programs are of great importance and in view of the current national health care crisis, this group of professionally excellent although neglected health facilities located in important urban and rural population centers are vital to our national health effort.

It may be that some of the hospitals have a 30% vacancy rate, but there are fewer beds available at other community hospitals. How can those hospitals absorb these patients? And how could the Universities afford to operate them?

It makes much beter sense to me, and I image the figures which HEW has been asked to submit to this Committee will show it, to improve the present facilities and extend the hospitals' authority to utilize the other 30% through such avenues as the Emergency Medical Personnel Act of 1970.

Mr. ROGERS. Thank you very much, Mr. Adams. We appreciate your helpful testimony.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Adams, for a strong statement which challenges some of the other testimony we have heard on a number of points. I think it is very helpful. Thank you.

Mr. ROGERS. Mr. Schmitz?

Mr. SCHMITZ. I have no questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. No questions.

Mr. ROGERS. Thank you very much. We may be calling on you, if we need additional information.

Mr. ADAMS. Thank you very much, Mr. Chairman. I appreciate the committee's courtesy.

Mr. ROGERS. We are now pleased to hear from another distinguished colleague, the Honorable Clarence D. Long of Maryland, who has been most active in introducing legislation and getting cosponsors and an active interest in this whole matter.

The committee welcomes you and will be pleased to receive your testimony.

STATEMENT OF HON. CLARENCE D. LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. LONG. Thank you, Mr. Chairman.

I welcome the opportunity to appear before the Public Health and Welfare Subcommittee on this crisis in Public Health Service hospitals and out-patient clinics. I commend you, Representative Rogers, for holding hearings on this legislation early in the session. We all recognize you as one of the leading men in Congress. I am very happy to have you dealing with this.

As you know, I am the author of House Concurrent Resolution 98 and the main sponsor of identical resolutions, House Concurrent Resolutions 99 and 108 and 128. These resolutions provide for keeping all of the Public Health Service facilities open through fiscal 1972, and during that interval to have the HEW Secretary and Congress explore resources, capabilities, and position of these facilities in their communities to determine which, if any, should be closed.

I introduced this resolution, the first of its type in the 92d Congress, because of the Baltimore metropolitan area's need to keep its Public Health Service hospital open. The consequences of closing the hospital illustrate the need for careful study by HEW and the Congress of the proposed closing.

The fiscal 1972 budget confirmed rumors that I have been hearing for nearly 2 months about the hospital. Only $74.6 million will be available to operate the hospitals and clinics. This is a decrease of $26.1 million from the fiscal 1971 budget. This budget places emphasis on the use of service agreements with private and Federal sources to do the job that is now done by Public Health Service hospitals.

In addition, the budget only provides $15 million for salaries. This almost wipes out the salary budget, taking it down by $48 million, and reducing the employees from 6,242 to 970, which comes about as close to wiping a function out as you can get.

The situation has changed somewhat since 54 of my colleagues joined me on January 29 in introducing House Concurrent Resolutions 98 and 99. The administration seems to be considering two alternatives: one is closing the facilities because primary beneficiaries can get more economical health care in more modern facilities, or allegedly can get more economical care elsewhere; and, two, turning the facilities over to community operation. Either alternative would have serious consequences for Baltimore, and I imagine for other communities. These alternatives ought to be studied carefully.

For my constituents and other residents of the Baltimore metropolitan area, closing the hospitals would create no little hardship. The Maryland Hospital Association, which is united with other medical interests in opposition to closing the hospitals, has told me there are 7,373 hospital beds in the Baltimore area, and closing the Public Service Health hospital would mean a loss of 238. But they also plan to eliminate another 124 beds in two of the area Veterans' Administration Hospitals. Already, the hospitals in the area are operating at 86.6 percent of capacity compared with an ideal rate of 85, and taking on PHS beneficiaries would make them operate at nearly 90 percent of capacity.

Now, the cost in the Baltimore area private hospitals is a lot higher than the cost of the Public Health Service hospitals, even excluding doctor's visits for the private hospitals; so that the Public Health Service hospital is a more economical operation in the Baltimore area. That certainly has to be taken into consideration in this day when we just don't have money enough to do all of the things we want to do.

Another important thing that has to be brought out is that the President wants to expand his health care program tremendously and, of course, you can always build new buildings, but the big thing is to keep a team together. I have met with this team in Baltimore and I have rarely seen a more enthusiastic group of doctors and nurses. Once you let that group go, anybody that has ever run an organization, including a Congressman, knows what happens to you if you let your organization go and you have to rebuild it. It took me about 8 years to get a really perfect staff going, and I can imagine how long it is going to take to rebuild these hospital staffs if they are ever let go. Already they are beginning to give notice, because they see the handwriting on the wall.

We have to act now if we want to keep these teams together.

In regard to the second alternative, community control, this is going to create hardships for thousands of military personnel, their dependents, and retired military personnel who now get economical care at the hospital. In fiscal 1970 these people accounted for more than 50 percent of the patients admitted to the hospital and for nearly 50 percent of the more than 100,000 out-patient visits. Presently Fort Holabird, Fort Meade, and Aberdeen Proving Ground also provide medical care for area military personnel and their dependents. However, with the closing of Fort Holabird, the other two bases cannot easily absorb former Holabird patients in their own over-crowded

facilities—and would be hard-pressed to consider caring for the thousands that the Public Health Service treats. The Government absorbs the cost of their care in military hospitals and reimburses the Public Health Service for the cost at the Public Health Service Hospital, but only pays the "reasonable charges" on their bills—under the Uniformed Services Health Benefits Program (commonly referred to as CHAMPUS)—if they go to a private hospital for treatment. If the Public Health Service Hospital were community-operated, the individual CHAMPUS beneficiaries would have to work out their own medical care arrangements with the hospital.

These problems are troubling my House colleagues in the 21 other States which have Public Health Service facilities, but I think I can say this in all objectivity—these problems don't seem to be bothering the White House very much. Forty-four of my House colleagues joined me last month in asking for a White House level meeting with the congressional delegations and Governors of the affected States. We didn't necessarily ask the President to meet us. We asked for a responsible person at the White House level who understood the problem to meet with us and to talk about it. Because we understand this whole thing has been imposed on HEW by the White House and the Office of Management and Budget, it seems to me a resolution of this problem should come from there.

The White House hasn't indicated any concern. We haven't been able to get any satisfaction from them at all. White House-congressional communication has completely broken down on this problem. I did this without any effort to put them on the spot or without any effort to be partisan. It seemed to me it was a problem we could work out for the benefit of all of us.

The lack of interest on the part of the White House is all the more puzzling, since the President himself—and I think this was the best part of the state of the Union message—said one of his great objectives was to make health care more available more fairly to more people. I have probably as conservative a district as you will find anywhere in the United States. A questionnaire that I sent out—

Mr. SCHMITZ. I will invoke personal privilege.

Mr. LONG. I think we could give you a pretty good run, Mr. Schmitz. Approximately 85 percent of the people answering my recent questionnaire wanted to see health care greatly expanded. I think it is all the more puzzling that the President did not respond more positively to this important problem in view of the objective which he has stated.

In closing, Mr. Chairman, I want to say that I am heartened by your subcommittee's response to this health care crisis and I hope that the full committee will react to your leadership on this matter.

(Mr. Long's prepared statement follows:)

STATEMENT OF HON. CLARENCE D. LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Thank you, Mr. Chairman, I welcome the opportunity to testify before the Public Health and Welfare Subcommittee of the House Interstate and Foreign Commerce Committee on the crisis in the Public Health Service Hospitals and Outpatient Clinics.

I want to commend you, Representative Rogers, for holding hearings on this legislation early in the session. As you know, I am the author of House Con-

current Resolution 98 and the main sponsor of the identical resolutions—H. Con. Res. 99, 108, and 128. These resolutions provide for keeping all the Public Health Service facilities open through Fiscal 1972, and, during that interval, to have the HEW Secretary and the Congress explore the resources, capabilities, and position of these facilities in their communities to determine which, if any, should be closed.

I introduced this resolution—the first of its type in the 92nd Congress—because of the Baltimore Metropolitan Area's need to keep its Public Health Service Hospital and Outpatient Clinic open. The consequences of closing that hospital illustrate the need for careful study of the proposed closing by HEW and the Congress.

The Fiscal 1972 Budget confirmed rumors I had been hearing for nearly two months about the hospitals. Only $74,631 million will be available to operate the hospitals and clinics.

The 1971 budget provided $100,762 million for these operations. The 1972 budget decreases this amount by $26.1 million. Furthermore, the narrative reads: "The budget places emphasis on the use of service agreements with private and Federal sources for such care and the conversion of the existing facilities to community use." In addition, the budget provides only $15,115 million for salaries. The 1971 budget provided $63,889 million for salaries. This is a decrease of $48,774 million from the FY 71 budget. Finally, the FY 1972 provision for PHS employees is 970. The 1971 provision was 6,242 employees. This is a decrease of 5,270 employees. The Administration clearly intends to decrease its participation in the operation of these facilities.

The situation has changed somewhat since 54 of my colleagues joined me on January 29th in introducing H. Con. Res. 98. The Administration seems to be considering two alternatives: (1) closing the facilities because primary beneficiaries can obtain more economical health care in more modern facilities; and (2) turning the facilities over to community operation. Either alternative would have serious consequences for Baltimore that should be studied carefully.

For my constituents and the other residents of the Baltimore Metropolitan Area, closing the hospitals would create great hardship. The Maryland Hospital Association, which is united with all other Maryland medical interests in its opposition to closing the hospital, has told me that there are 7,373 hospital beds in the Baltimore area. Closing the PHS hospital would mean a loss of 238 beds. Moreover, two of the area Veterans' Administration Hospitals have been ordered to eliminate a total of 124 beds by the end of Fiscal 1972. Closing the hospital and curtailing Veterans' Administration services would be a loss of 362 beds to the Baltimore Area population. If the VA Hospitals are unable to care for primary beneficiaries on a contract basis, an arrangement would have to be worked out with the community hospitals. These hospitals are operating at 86.6% of capacity. If the PHS Hospital beds are eliminated the occupancy rate would increase to 89.1%, according to the Maryland Hospital Association. However the ideal average occupancy rate is 85%.

Furthermore, patient care in the Baltimore area hospitals is $85 per day per bed—without counting the cost of attending physician's visits. The Public Health Service Hospital charges are $79.52—including doctor's visits.

Finally, Maryland would lose the Public Health Service team, expertly administered by Hospital Director Dr. Edward Hinman, the NIH Cancer Research Center, and the training programs for medical personnel which are operated in conjunction with the Johns Hopkins University, the Universities of Maryland and Pennsylvania, and local community colleges. Private citizens would lose use of emergency room facilities when other city hospitals are full. Closing the hospital would prevent implementation of plans to provide low cost health care to residents of the Homestead-Montebello area.

The second alternative now under consideration—community control—might create hardships for the thousands of military personnel, their dependents, and retired military personnel who now receive economical health care at the hospital. In Fiscal 1970 these people accounted or more than 50% of the patients admitted to the hospital and for nearly 50% of the more than 100,000 out-patient visits. Presently Fort Holabird, Fort Meade, and Aberdeen Proving Ground also provide medical care for area military personnel and their dependents. However, with the closing of Fort Holabird, the other two bases cannot easily absorb former Holabird patients in their own overcrowded facilities—and would be hard-pressed to consider caring for the thousands that the Public Health Service treats.

The government absorbs the cost of their care in military hospitals and reimburses the Public Health Service for the cost at the Public Health Service Hospital, but only pays the "reasonable charges" on their bills—under the Uniformed Services Health Benefits Program (commonly referred to as CHAMPUS)—if they go to a private hospital for treatment. If the Public Health Service Hospital were community-operated, the individual Champus beneficiaries would have to work out their own medical care arrangements with the hospital.

Similar problems are troubling my House colleagues in the 21 other states that have Public Health Service facilities. These problems do not seem to be bothering the White House very much. 44 of my House colleagues joined me last month in requesting a White House level meeting with the Congressional Delegations and Governors of the affected states to discuss the crisis. The White House has not indicated its concern or interest in convening the meeting. Yet eliminating any of the PHS services seems inconsistent with the President's State of the Union goal to make health care "available more fairly to more people."

In closing, Mr. Chairman, I want to say that I am heartened by your Subcommittee's response to this health care crisis, and I hope that the full committee will act promptly on this legislation. I look forward to early consideration on the House floor so that we can achieve a resolution of this crisis.

Mr. ROGERS. Thank you very much, Congressman Long, for an excellent statement.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

I would like to welcome our colleagues. I think that you have really summarized the problems most of us have in our own areas where we have either clinics or hospitals. I would like to ask you if you know whether the administartion as yet has made a survey to see if other comparable facilities are indeed available to pick up the caseload in the event they closed your hospital in Baltimore?

Mr. LONG. That is what the purpose of this resolution House Concurrent Resolution 98 is, to get such a survey made. No really comprehensive survey has been made. They have looked at the very narrow question, as I understand it, of whether the hospitals are adapted or equipped to meet the narrow needs of the merchant seamen, but no one has looked into the broader question of what would happen to the private hospitals in the area if you closed these Public Health Service hospitals. Would they have the money to treat these patients? Would veterans and other Government hospitals be able to handle the load? Would the community?

This hospital is close by the Homestead-Montebello community of about 30,000 people, 75 percent black. And I believe this is accurate, there isn't a single resident physician or a nurse in that entire area. This hospital is ideally located to cope with that demand. And closing it down is going to create a tremendous vacuum that is going to have to be helped.

Admittedly, this hospital has not been serving that community before. But, under the new 1970 mission that was given by Congress to the Public Health Service hospitals, in the Emergency Health Services Personnel Act, this could be done.

Mr. KYROS. I think you also brought out this very good point that, even if we did make the study to see about the option of having contracts made by the Public Health Service with private or public hospitals, there hasn't been any cost study. I believe you pointed out that such studies, as far as you know, might well indicate higher costs.

Mr. LONG. No question about it, substantially higher, even without counting doctors' visits.

Mr. KYROS. So, if we pursued House Concurrent Resolution 98 with a study, we could come out with a uniform idea of how to achieve the best medical care for the cheapest price without touching these hospitals.

Mr. LONG. Exactly.

Mr. KYROS. Thank you very much.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman. I wish to welcome my colleague. I would like to point out in the testimony by Dr. Egeberg, that he said it is not necessarily true that these hospitals will be closed. I think that HEW is presently doing the very thing that you are suggesting and is examining the need, and where they find it exists, the hospital will not be closed.

As I understand it, the Public Health Service objective is to make the facility unused capacity available to a community. Rather than used for just one group of patients, the hospital should be available to others so that its total capacity would be used.

In many cases the hospitals are operating only at a percentage of total capacity. But I laud your concern and certainly that of the chairman and perhaps our committee should go out and take a look at one of these hospitals. Maybe there are things we need to do to harness the total facility so that it will be capable of performing the services necessary.

I thank the gentleman for his testimony. We will do the best we can on each local problem.

Mr. LONG. I am sure you will, Mr. Nelsen. I must say there is a good deal of vagueness here. The administration has been talking about doing what you say and yet, this is totally inconsistent with cutting the staff down to 970.

You won't really have a hospital there unless we act on my resolution. So I would say, if that is what the administration wants to do, then the resolution which my colleagues are sponsoring would help to achieve that.

Mr. ROGERS. Thank you.

Mr. LONG. Right now, the hospitals feel they are going to be closed or at least they are going to be functioning at such a low level of staff that they would not be able to do anything.

Mr. ROGERS. Until another budget request comes in, the present budget envisions the closing of the hospitals and clinics.

Mr. LONG. Exactly. Suppose you were a member of the staff of one of these hospitals and you saw that kind of budget, and it was well-publicized, wouldn't you be looking for another job? It is a miracle that they have been able to keep the staff together. I think it is because they are so enthusiastic about the mission that they have to perform that they have been staying on a little longer. But I think it would be in their own self-interest to look for jobs elsewhere unless Congress does something to improve their morale.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. I have no questions. Thank you, Mr. Long, for your statement.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I have no questions. Thank you.

Mr. ROGERS. Thank you very much.

Our next witness is our distinguished colleague who has just been elected to this Congress, the Honorable Parren J. Mitchell from Maryland, who also is very much concerned about this matter.

We are pleased to welcome you to the committee and to hear your testimony.

STATEMENT OF HON. PARREN J. MITCHELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. MITCHELL. Thank you very much, Mr. Chairman. I have, of course, cosponsored both of the resolutions because of my very deep interest in this problem.

I have a prepared statement.

Mr. ROGERS. We will make it a part of the record, without objection, and then if you will comment on the high points.

Mr. MITCHELL. I will refer you to page 5 and I will begin commenting and reading from that point.

My colleague, Congressman Long, talked about community control which I would oppose as of this time, but I do feel the specific need for community involvement of the Public Health Service hospital. In addition, Mr. Nelsen has indicated an interest in the kinds of community involvement which would make the institution more viable.

What I would like to share with you is the fact that in Baltimore the public hospital is prepared to enter into that kind of involvement.

Had it not been for what I consider a capricious and rather cruel decision made by the White House, the program of community involvement would now be in effect.

I want to share with you a few details concerning the impact of closure on Baltimore City with specific reference to the black community in Baltimore City.

The area surrounding U.S. Public Health Service Hospital faces the mounting problems of blight. In many of the city's communities, a large portion of the white residents have migrated toward the suburbs taking with them the providers of basic health services.

Homestead-Montebello, the area in which the hospital is located, is such an area. In two of the five area census tracts there has been 80 percent migration from white to black in the past 2½ years.

There are literally no full-time doctors, no dentists, no pharmacists to serve the community. The residents of Homestead-Montebello are struggling to halt the deterioration of their community but they cannot do it alone. Efforts in the health area have been far more encouraging than in other areas.

The community leaders who have worked so hard to move forward in this health area were, of course, disturbed about critical health problems and approached the Baltimore City Health Department for assistance.

City officials in turn suggested a meeting with the staffs of Wyman Park Hospital and two other provider groups. The meeting generated new hopes and enthusiastic cooperation between neighborhood residents, city officials, and hospital staffs.

The plans which finally emerged contributed the most constructive solution to health care that I have seen. As an official in State and city

government for more than 15 years, I have been deeply enmeshed in this whole problem of health care.

Initially, 6,000 individuals from Homestead-Montebello families are to be involved in a prepaid comprehensive health care program to be administered by the U.S. Public Health Service Hospital in close cooperation with a corporation of citizens and medical providers.

Neighborhood residents would participate in the project and jobs would be created in community liaison work, local administration and paramedical professions. The health center is to be set up in the community to promote involvement and to provide easy accessibility. One of the remarkable things about this hospital at Wyman Park is that, as of this moment, the hospital is prepared to give a complete medical evaluation in as little as 90 minutes. I hope you realize the significance of this when we are talking about an area which is so sorely lacking in private medical facilities.

The program that is proposed stresses preventive medicine and one-class care. It makes maximum use of scarce, highly specialized medical professions.

New jobs would be created for unskilled and semiskilled workers with these great strides toward a solution for community health problems. Discussions are currently underway. Plans are to eventually expand the program to involve all north central Baltimore through establishment of additional satellite health centers.

All of these health centers would feed into our U.S. Public Health Service hospital.

Mr. Chairman, and members of the committee, I think it would be inexplicably tragic to dash the hopes and expectations of citizens and hospital personnel involved in this project.

From my point of view, it would be inexcusable to cut off the livelihood of numerous city residents now employed by the hospital and terminate on-going community services.

Let me make a comment on EOC aspects of the problem. As you well know, unfortunately, many times our government commits itself to equal employment hiring policy and then reneges or fails to live up to its commitment.

This has not been the case at the U.S. Public Health Service. The Wyman Park Hospital has vigorously enforced equal employment standards for many years. Of 650 employees, 40 percent of civilian employees and 10 percent of commissioned officers are black citizens. Total payroll is $20,000 per day or $7.3 million per year.

I will simply indicate that there is a tremendous involvement of the hospital in a number of other federally-funded projects throughout the area. I want to comment on something that Congressman Long said in reference to the degree of dedication that exists at this hospital. The Public Health Service Hospital is not a self-perpetuating institution, clinging to its existence for reasons of self-interest. It represents a highly progressive, responsible, and self-critical group of individuals who are offering solutions to our critical problems of health care delivery. They are providing alternatives to divisiveness in our society and alienation of citizens from Government.

It was interesting that the President spoke about the alienation that he has witnessed so far. He mentioned this in the state of the

Union address. I think the people at hospitals are answering the cry of cynicism and despair.

They are showing that we can work together for a better society for all. I have cosponsored both of the resolutions introduced by my distinguished colleagues, Messrs. Garmatz and Long, and I urge that the funds be made available to continue and not only continue, but to expand the operation of the U.S. Public Health Service hospitals and out-patient clinics so they may continue to provide leadership in the movement for adequate health care for all.

One last statement, Mr. Chairman, and members of the committee. I read time and time again all of the lamentations and all of the statements about why is the black community always upset, why is the black community not satisfied with the progress that is being made? And I think in a kind of microcosm, we have an explanation for that unrest and that lack of satisfaction.

At the precise juncture in history when a U.S. Public Health Service Hospital, a governmental agency, has moved for the involvement of blacks in a constructive, effective program, it is at that precise juncture that the White House, in a gesture of absolute cynicism and contempt, dashes the hopes of these black citizens. That is a part of the issue as well as the health service.

I thank you very much for letting me appear before you.

(Mr. Mitchell's prepared statement follows:)

STATEMENT OF HON. PARREN J. MITCHELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman: Other speakers have well documented the excellent comprehensive health care services which the United States Public Health Service Hospitals and Out-Patient Clinics provide for primary beneficiaries and other federal government personnel and dependents including: Merchant Seamen, active and retired officers and enlisted men of the Coast Guard and Armed Services, Officers of the Oceanic and Atmospheric Administration, and U.S. Public Health Service Personnel. It also has been made perfectly clear that we are woefully deluding ourselves if we think such services can be taken over by Veterans Administration Hospitals and other public and private medical institutions, on a contractual basis.

In Maryland, to my knowledge, none of the local Veterans Administration Hospitals have facilities for children, none provide comprehensive health care and none have complete services for women. Also, it is a well known fact that these hospitals are overcrowded, understaffed, and under-financed. If the U.S. Public Health Service Hospitals and Clinics are closed, the present beneficiaries will cruelly be left out in the cold. I would find this a grave act of bad faith on the part of the Federal Government, which assumed responsibility for the medical care of these personnel. I fail to see how the beneficiaries could view the closure as anything but a slap in the face, and the numerous letters I have received on this issue confirm my conclusion.

I wish, however, to address myself today to the staggering effect closure would have on the communities in which the hospitals are located. I would like to elaborate by using the example of the Wyman Park Hospital in Baltimore, and to talk about the people who are currently employed and being trained by the hospital, about the community groups which have new hopes and expectations for their community as a result of the hospital's cooperation, about the enthusiastic hospital personnel who are looking forward to the prospect of working to alleviate the critical health problems of the neighborhoods surrounding the hospital. In the broader sense, I wish to talk about the self-dignity of individuals, about the attitudes of communities toward problem solving and about the relation of citizens to their government.

We are in difficult times. The gluttonous budget consumes our financial and human resources for an unpopular war in Southeast Asia, inflation and

unemployment run rampant, crying needs of our cities are callously ignored, and despair is the dominant reality of our nation. This cannot continue. We must begin to repair the fabric of our society, not with safety pins, but with strong thread and careful stitches to reweave the torn pieces into a cohesive whole.

Mr. Nixon seemed to share these sentiments and to be willing to tackle our pressing problems when he said in the State of the Union Message, "In these troubled years just past, America has been going through a long nightmare of war and division, of crime and inflation. Even more deeply, we have gone through a long, dark night of the American spirit. But now that night is ending. Now we must let our spirits soar again. Now we are ready for the lift of a driving dream."

A part of such a dream is on the brink of becoming a reality for the people of Baltimore. Through the constructive combined effort of neighborhood organizations, the Baltimore City Health Department and the Wyman Park Public Health Service Hospital, a progressive plan for community health care delivery was created. The program is in jeopardy and we cannot allow this dream to degenerate into a nightmare of frustrated efforts, thwarted plans and further neighborhood deterioration. Our city is crying out for help in the area of health care. The staff of the Public Health Service Hospital is geared up and ready to move toward the implementation of a system of community health maintenance. The U.S. Congress sanctioned expansion of public health service into communities where health personnel, facilities and services are inadequate. The President gave his stamp of approval by signing into law the Emergency Health Personnel Act of 1970.

And yet, when we look at the Budget of the United States Government for 1972, we see that it has been cut so as to effectively prevent the continuation of the Public Health Service Hospitals and Clinics. The following are points which must be considered with the utmost seriousness. They relate to the information found on pages 402–405 of the Budget Appendix. (Round figures are used throughout.)

(1) The budget authority for FY/71, $84,000,000, represents a cutback of operating programs. In order to maintain current programs in FY/71, this figure should be substantially increased.

(2) The budget authority for FY/72 should be raised to a figure closer to $100,000,000, if the rising costs of maintaining present programming at all levels are calculated into the budget request.

(3) The FY/72 request to Congress states that the "budget places emphasis on the use of service agreements with private and Federal sources for such care and conversion of the existing facilities to community use." This apparently indicates health care for the primary U.S. Public Health Service beneficiaries will be contracted out to other institutions.

(4) 1971 personnel compensation, estimated at $64,000,000, reflects an imposed cut-back in employees ranging as high as 5% from FY/70.

(5) A realistic personnel ceiling for FY/71 should have been substantially more than 6300. In the FY/72 estimate, there are provisions for only 970 employees. This could only indicate staffing provisions for central administration of the federal health care program from Washington. All services evidently would be contracted out to other medical institutions.

(6) The appropriation for FY/72 to cover buildings, facilities, and other direct construction items of the Federal Health Programs Service is listed in the Budget as $91,700,000. By their own testimony, Administration officials admit that the amount should be significantly raised. It should be noted, however, that none of these funds are appropriated for FY/72, which again indicates the Administration's intentions to close down the facilities.

The Administration has not publicly stated its position on closure. However, the intended fate of the U.S. Public Health Service Hospitals and Clinics is no where more clearly indicated than in the above figures. This cannot be tolerated. Too much is at stake.

Let me share with you a few more details concerning the impact closure would have on Baltimore City.

The area surrounding the U.S. Public Health Service Hospital faces the mounting problems of urban blight which plague all of our major urban centers. In many of the city's communities, a large portion of white residents have migrated toward the suburbs, and with them have gone the providers of basic

health services. Homestead-Montebello is such an area. In two of the five area census tracts, there has been over 80% migration from white to black in the past two and one-half years. There are literally no full-time doctors, no dentists, and no pharmacists to serve the community.

The residents of Homestead-Montebello are struggling to halt the deterioration of their community, but they cannot do it alone. Efforts in the health area have been encouraging. Community leaders who were dismayed about the critical health problems approached the Baltimore City Health Department for assistance. City officials, in turn, suggested a meeting with staffs of the Wyman Park Hospital and two other provider groups. The meeting generated new hopes and enthusiastic cooperation between neighborhood residents, city officials and the hospital staffs. The plans which finally emerged exhibit the most constructive solution to community health care I have ever seen.

Initially, 6,000 individuals from Homestead-Montebello families are to be involved in a pre-paid comprehensive health care program to be administered by the U.S. Public Health Service Hospital in close consultation and cooperation with a corporation of citizens and medical providers. Neighborhood residents would participate fully in the decision making process and jobs would be created in community liaison work, local administration, and para-medical professions.

A Health Center is to be set up in the community to promote involvement and provide easy accessibility. Preliminary health examinations would be made at the newly established Multi-Phasic Health Testing Center at Wyman Park, where complete medical evaluations can be made in as little as 90 minutes. Financial arrangements for payment would be worked out with the individual or through the State Health Department Title 19 provisions, the Blue Plans, and other health insurance plans. Administrators of both major programs have indicated receptivity to the proposal.

The program stresses preventive medicine and one class care. It makes maximum use of scarce, highly specialized medical professionals. New jobs would be created for unskilled and semi-skilled workers in the great strides forward toward a solution of the community's health problems.

Discussions are currently underway with a broader group of community organizations, the North Central Baltimore Health Consortium. Plans are to eventually expand the program to involve all of North Central Baltimore through the establishment of additional satellite Health Centers. All would feed into the U.S. Public Health Service Hospital.

It would be inexplicably tragic to dash the hopes and expectations of the citizens and hospital personnel involved in this project. It would be inexcusable to cut off the livelihood of numerous city residents now employed by the hospital and to terminate the on-going community services.

The Wyman Park Hospital has vigorously enforced its equal employment standards for many years. Of the 650 employees, 40% of the civilian employees and 10% of the commissioned officers are black. The total payroll is $20,000 per day or $7.3 million per year.

Some of the on-going community services include: cooperation of hospital pediatricians to alleviate the tremendous shortage of school physicians in the community, Youth Opportunity Corporation and Neighborhood Youth Corps Anti-Poverty programs, College work-study programs, accredited para-medical training programs for Nurses Aides (under the Manpower Development and Training Act), Physical Therapists, Medical Record Librarians, Laboratory Technicians and Pharmacists. Most of the programs are affiliated with institutions in the community which serve minority groups, such as community colleges and public schools.

The Baltimore Public Health Service Hospital is not a self-perpetuating institution, clinging on to its existence for reasons of self-interest. It represents a highly progressive, responsible, innovative and self-critical group of individuals who are offering solutions to our critical problems of health care delivery. They are providing alternatives to the divisiveness in our society and to the alienation of citizens from their government. They are answering the cries of cynicism and despair. They are proving that we can overcome our tremendous problems and lack of communication. They are showing that we can work together for a better society for all. I therefore have co-sponsored House Concurrent Resolutions 98 and 149, introduced by my distinguished colleagues, Congressman Long and Garmatz respectively. I strongly urge that funds be made available to continue and expand operation of the U.S. Public Health Service Hospitals and Out-Patient Clinics, so they may continue to provide leadership in the movement for adequate health care for all.

Gentlemen, thank you for your time.

Mr. ROGERS. Thank you, Mr. Mitchell, for your statement. And the point you have brought certainly will be considered by the committee.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

I want to welcome our colleague.

I don't fully understand page 5 of your statement. In other words, in the bottom paragraph, the Public Health Service hospital is cooperating in and planning a prepaid comprehensive health care program.

Mr. MITCHELL. That is correct. The citizens, themselves, are involved in the development of this comprehensive care. The administration can be taken on by the U.S. Public Health Service.

Mr. KYROS. So that makes the hospital there even more important?

Mr. MITCHELL. It is absolutely integral to the well-being of that community.

Mr. KYROS. As far as you are concerned, it would be difficult to have any alternatives. I don't see anything cited in your statement about alternative facilities for care in the area.

Mr. MITCHELL. There is none. The facilities in Baltimore City, as in every other large urban center, are strained, and I think it is awareness of that strained condition which has caused the Johns Hopkins Hospital and all of the other major hospitals in the Baltimore area, as well as Baltimore City Health Department, to be totally supportive of this program which is proposed for Wyman Park Hospital.

Mr. KYROS. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

I want to thank Mr. Mitchell for his fine statement and I want to also call attention to the fact that in my questioning of Dr. Egeberg, I asked the question, "Now, Dr. Egeberg, if you find a hospital fills a necessary function in a community, is it your intention to close it?" And he said, "No."

I also want to point out that the things that have been done in Baltimore by the way of community involvement is the very thing that HEW feels should be effected. It may very well be that you have given an example of what may be the intention of the people located near the hospitals and I would certainly want to see the hospital give the service that you have indicated. This action is certainly to be lauded and something to be encouraged. What has been shown by the action taken is an admission that the previous arrangements were not satisfactory and that you need to get more community involvement, which is what I was told was the intent of the Public Health Service.

I think we will come up with some pretty good answers and maybe we need to move toward more community involvement with our Public Health Service hospitals. Perhaps we should not get excited about closing them because it may develop all of them are needed.

Mr. MITCHELL. May I make one comment on that and I will be finished.

This is the thing that is so very disturbing. I have been in antipoverty work. You get a mandate from HEW, "Go out and seek involvement of the community." And the same administration operating on another plane negates that mandate after the community has done this.

Mr. NELSEN. Right.

Mr. MITCHELL. I, for one, am sick and tired of the administration playing what I consider to be a national "confidence" game with the lives of poor people and black people, a sort of now you see, it now you don't. I frankly am weary of it.

Mr. NELSEN. Thank you.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you.

Mr. Mitchell, I think you have made an excellent point that we need to always keep in mind what happens when white flight occurs. When you have the white migration to the suburbs, it takes with it all of the medical services from the Corps centers as well as many people.

I certainly congratulate you on the Community Health Plan which seems to me very innovative and creative and I would agree with you that it is unthinkable that such a plan would be stopped in its tracks by closing the hospital and I agree with Mr. Nelsen that I can't conceive of HEW closing a hospital in this situation.

But your statement is certainly a good, strong one and I think we need to keep that position before we make sure they don't close it.

Mr. MITCHELL. Thank you, Mr. Preyer.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I have no questions.

Mr. ROGERS. Mr. Schmitz?

Mr. SCHMITZ. I have no questions. I just have a comment. I think our colleague, Mr. Mitchell, has pointed out a problem, which arises any time Government gets too much into this field. Then you are going to have a schizophrenic or two-jointed policy decision, you are going to be going off in many different directions. I don't think it is a problem of this administration. I think it is a problem caused by getting Government into an area that is best handled by other agencies, and I think we will find it more and more as we go along in this direction.

Mr. MITCHELL. I think that is an argument I would not want to enter into at this time. If I properly understand what you are saying, I would be in violent disagreement with you. I think Government must of necessity move in areas that have been neglected by the private sector.

Mr. ROGERS. Thank you very much. We appreciate your testimony.

Our next witness is the Honorable Dan Kuykendall, a member of the full committee. Welcome, Mr. Kuykendall, proceed as you see fit, sir.

STATEMENT OF HON. DAN KUYKENDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. KUYKENDALL. Mr. Chairman, members of the subcommittee, thank you for giving me this opportunity to speak in behalf of our sorely needed medical facilities, and for the U.S. Public Health Service clinics and hospitals in particular.

As one of the cosponsors of House Concurrent Resolution 98, I can tell you that the entire thrust of the resolution is summed up in the

sentence stating that the Secretary of Health, Education, and Welfare should, during a so-called grace period, explore the resources, capabilities and position of these facilities in the community to determine which of them, if any, should be closed.

Budget cutting is wonderful, and no one is more in favor of it than I, if I assume that those in charge of the cutting are pruning the tree, and not trying to chop it down. Budget cutting with an axe instead of a scalpel, as I believe this to be, is as reckless as indiscriminate spending—and just as dangerous.

We have here a situation in which 30 clinics and eight hospitals suddenly have the fiscal rug pulled out from under them. It goes without saying that the geographical and economic factors in each of these 38 locations cannot be identical. Perhaps some of them have outlived their usefulness; I cannot say for sure, though I would look long and hard at the closing of any health facility at this time when the Nation's needs in this area are so great. But I can tell you from personal experience, the clinic in Memphis has not outlived its time and its value to the community it serves. As for the proposal to utilize the Veterans' hospital facilities or contract with private hospitals, I can only tell you that extra beds are at a premium in all of our excellent hospitals in Memphis, and if you mention an extra bed at the VA hospital, they hope you're talking about a sleeping bag in your motel room.

Outpatient services are even more critical in Memphis, and all we are asking is for someone in H.E.W.'s budget department to assess these shortages before swinging the axe.

We are confident that if they do, they will find the clinic in Memphis performing a worthwhile function that would merit its continuation.

Thank you.

Mr. ROGERS. Thank you, Mr. Kuykendall. Are there any questions? If not, then thank you again, sir.

Mr. KUYKENDALL. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is our distinguished colleague, the Honorable Paul L. Sarbanes of the State of Maryland. He, too, has shown an interest in this matter and we are pleased to welcome him to the committee and will be glad to receive his testimony and it will be made a part of the record, without objection. If you would like to highlight any particular points, the committee would be pleased to receive your testimony.

STATEMENT OF HON. PAUL S. SARBANES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. SARBANES. I will try to be very brief.

Thank you, Mr. Chairman.

I want to make a few comments to supplement the statement that has been included as a part of the record. At the outset I want to express my appreciation to you, Mr. Chairman, for the action you took in early December in bringing to the attention of all of us and the public what the administration was moving to do with respect to the public health hospitals and clinics.

I am convinced that your action shifted the momentum and impetus from the executive to the legislative. Had it not taken place, I am fearful the executive would have proceeded down the path of closure to an extent that might have made it impossible for us to turn the decision around. I think a good deal of the reasonableness that is now being evidenced by the Department of Health, Education, and Welfare is as a consequence of your actions and subsequent events that have taken place.

I would only like to point out with respect to the Public Health Service facility in Baltimore, first of all, that it is meeting its existing responsibilities extremely well. I doubt that anyone could survey a group of beneficiaries involved in a health care system and find as much satisfaction as exists with respect to the service that is being provided by that facility.

Entry into the health care system is easy. They have developed a number of techniques oriented to the consumers of health care and I would say that they are discharging their existing responsibilities in a very high quality manner.

Second, that hospital has taken a number of innovative steps in an effort to involve itself in a number of health care problems. You have heard already from some of my colleagues of the efforts they are making to develop a prepaid comprehensive health care plan to serve an area of the community that is now virtually without health care facilities. There is at that facility the Baltimore Cancer Research Center which is a clinical facility of the National Cancer Institute. The research center has been doing outstanding work in chemotherapy treatment of cancer and is a part of the research effort being carried on by the National Cancer Institute.

I think it is interesting that the President's state of the Union message on January 22 emphasized health care and the subsequent followup health message by the administration emphasized health maintenance organizations, the HMO's. This is directly what this hospital has been trying to do in developing a comprehensive health care plan.

Second, the President emphasized cancer research, and indicated he was going to make an additional appropriation specifically for that purpose. Once again this is directly what this facility, which has a major cancer research unit, has been doing.

So in both instances it seems to me that the administration's professed goals in the health care field and its actions with respect to this health care facility are contradictory and inconsistent.

Besides the substance of what is taking place at the Baltimore hospital, the statement details a number of other things that are going on there that are very important, I think one ought to focus for a moment on the decisionmaking process which has been followed with respect, not only to this facility, but to all of them across the country.

In 1965 there was a study of the Public Health Service system by an outside group which recommended keeping it, upgrading it, modernizing it, and having it as an integral part of the national health program.

Second, the survey teams that were recently sent out, were, in my judgment, after the fact and in response to the hue and cry that had been raised by the Congress. I believe the survey was an effort to justify a conclusion that they had already tentatively arranged.

I am delighted to hear that you have obtained those survey reports and I think it will be very interesting to see what they show. Third, there was no effort by the Department to consult with local health planning agencies who are charged with responsibility for comprehensive health planning under the partnership for health concept which is an integral part of Federal legislation.

I am frank to say to you that for a decision of this magnitude, whose consequences are as enormous as what the administration has proposed, I think the process has been inexcusable. It really has been an extremely bad decisionmaking process and it is only after the fact that efforts have been made to begin to do the kind of consultation and the kind of research and the kind of examination which obviously should precede and not follow such a decision.

The impact of this process has been enormous because you are dealing in many instances with highly trained and skilled people. To build institutions is not easy to do. Morale in many of these institutions is extremely high. The administration's approach to the entire situation has been most harmful.

A number of people have left. A number of people are considering leaving. The director of the hospital and the heads of the staff are doing everything they can to try and hold it together. There is about it all, given the way the administration has gone at it, a self-fulfilling prophecy. If you do not support the institutions, if you create enough doubt about their future, then in fact a deterioration will set in almost automatically which then is used as a justification for the result you wanted to achieve to begin with.

The one final point I would like to make is that any talk of savings is completely illusory. There have been suggestions that the patient load would be shifted to the Veterans' hospitals. It could not be so handled in our area. The Veterans' hospital is overloaded now with respect to its existing responsibilities. There has been talk of shifting it to the community but it is not clear that with that talk goes the concept of shifting the resources to support the activity. Unless you do that, the shifting is really a budgetary gimmick, for somewhere someone is going to have to pay the cost of providing this health care and this has been health care supplied at an extremely low cost of a very good quality. Somewhere, someone is going to have to pay that cost, or people are not going to get health care who are now getting it. So, any talk of saving is really an illusion in my judgment.

We are very grateful to the committee for taking on this important problem. I believe these hearings will have an enormous impact, not least of which, I hope, will be to reassure the people in the field that in fact those institutions are not going to be destroyed either in the short run or in the long run.

Thank you, Mr. Chairman.

(Mr. Sarbanes' prepared statement follows:)

STATEMENT OF HON. PAUL S. SARBANES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, I would like to testify in support of House Concurrent Resolution 98 and House Concurrent Resolution 149, which would continue the operation of the U.S. Public Health Service hospitals and clinics.

I am opposed to the closure of the U.S. Public Health Service hospitals. These facilities which are located in eight cities—Baltimore, Boston, New York, Norfolk, New Orleans, Galveston, San Francisco, and Seattle—have consistently provided

first-class medical care to seamen, active and retired personnel of the uniformed services—Army, Navy, Air Force, Marines, Coast Guard, Public Health Service, and Environmental Science Services Administration—and dependents of such personnel.

The Public Health Service Hospital on Wyman Park Drive in Baltimore is located in the district which I have the honor to represent. It was built in 1932 and provides services for the classes of people for whom the Federal Government has assumed medical care responsibility. Since Baltimore is one of the nation's major ports and since this area has a great number of facilities involving the Uniformed Services, the number of people entitled to Public Health Service care under existing Federal law is quite large. Last year approximately 4200 people were admitted to the Hospital and there were over 108,000 clinic visits. The Maryland Hospital Association in telegrams to the Administration has clearly stated that private hospitals in the Baltimore area would be unable to absorb the caseload of the PHS hospital should it be closed. Furthermore, any thought of shifting such a caseload to the Veterans Hospital is illusory because that hospital is already confronted with severe problems in meeting its current responsibilities.

Perhaps of greater importance in considering the role of the Baltimore P.H.S. hospital is that it has been one of the most innovative hospitals in the state. This Administration hardly needs reminding that the provision of medical care is one of the primary issues facing the country. The P.H.S. hospital in Baltimore is an outstanding facility which has taken the lead and initiative in a number of respects:

1. The Hospital has been involved in planning with community groups for the establishment of a comprehensive prepaid health program in an inner city area where the availability of private medical services is almost nonexistent.

2. Early in 1970 the Hospital established a Health Evaluation Center which gives patients comprehensive health examinations, including an evaluation by a physician in just two and one-half hours—a fraction of the time and with fewer personnel than would be required in a conventional clinic.

3. The only school for Medical Record Librarians in Maryland is at the Public Health Service Hospital and I believe it is the only such school under the jurisdiction of the Federal Government.

4. The Hospital has close working relations with the schools in the area, including not only medical schools but also the community colleges. Such efforts to develop health care personnel through community college programs is generally viewed as a significant way to meet the critical shortage of personnel in the field.

5. Furthermore, the Hospital in cooperation with the Baltimore City Department of Education under a grant pursuant to the Manpower Development and Training Act has trained over 150 hard-core unemployed poverty people as nurses aides, all of whom were subsequently placed in jobs.

6. The Baltimore Cancer Research Center which is financed by the National Institute of Health is located at the Hospital and is jointly administered by N.I.H. and the Hospital. Over a period of time outstanding research facilities and, more importantly, an outstanding research team have been developed, all of which are now jeopardized by the proposed action concerning the Hospital. Surely, a total national commitment to achieve the goal of conquering the dread disease of cancer requires keeping this major cancer research unit in being.

7. It should be noted that the Hospital employs 661 persons and more importantly, that over 40% of the civilian employees are minority group members. The Hospital has a very active equal employment opportunity program which has achieved very significant results.

Given the medical care problem facing the nation today, the closing of the Public Health Service hospitals are typified by the one in Baltimore would be a regrettable step backwards. It would mean that Baltimore would lose a dynamic forward-looking medical institution which is playing a major role in facing and meeting the health care problem. Furthermore, to the extent that economy reasons are advanced for the proposed closing, the reasons are spurious for there would merely be a shifting of health costs elsewhere at greater total expense.

I also want to add that I am disturbed by the lack of in-depth study by the Department of Health, Education, and Welfare and the Office of Management and Budget which seems to lie behind this decision to close the Public Health Service Hospitals. Only after the decision had apparently been reached did the

Department send out fact-finding teams to look into and evaluate the particular situation in each area. At no time up to that point had there been consultation by the Department with local health planning agencies who are charged with responsibility for comprehensive health planning under the "partnership for health" concept contained in Federal legislation.

Finally, Mr. Chairman, as one of the co-sponsors of House Concurrent Resolution 98, and House Concurrent Resolution 149, I would like to urge that this subcommittee favorably report these resolutions. I trust that once the Congress has acted in support of these measures, the Administration will continue operating and improving the remaining 8 Public Health Service Hospitals and the 30 outpatient clinics that are so desperately needed if we are to achieve the great national goal of improving America's health care.

Mr. ROGERS. Thank you, Congressman Sarbanes. We appreciate your testimony and I think what you have said is true. I don't think there will be any saving. In fact, I think it will cost more to move away from the Public Health hospital setup as it exists now. Of course, this committee and the Congress has just passed the Emergency Health Personnel Act, which is to bolster the Public Health Service and to give it increased responsibility.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

I would like to commend our colleague for bringing to our attention the fact that the Baltimore hospital has these innovative programs in cancer research and in medical record librarians. And do they incorporate them into the Federal hospital system?

Mr. SARBANES. That is right. It is the only one in the Federal system and the only one in the State of Maryland.

Mr. KYROS. What is so novel about this comprehensive health examination other than that it is so highly efficient?

Mr. SARBANES. First of all, they use facilities in the evening which in the daytime are used for other purposes so there is a maximizing of the use of facilities.

Second, they have established a system that has attracted national attention in terms of their ability to process and provide these medical examinations in a very thorough way and in a very short period of time.

Mr. KYROS. I understand that you are training 150 hard-core unemployed people as nurse's aides in the hospital?

Mr. SARBANES. The hospital developed a training program in cooperation with the city to train hard-core unemployed and has done an invaluable service in that area.

Mr. KYROS. It seems to me that even if these facilities were converted, it is doubtful there is anyway you could contract all of these programs and projects we just mentioned?

Mr. SARBANES. I don't believe so, because what you have is an institution that has put together a mix of activities. As the chairman pointed out, if you want talk about inconsistency in the administration's attitude, the President signed right at the end of 1970 the Emergency Health Personnel Act and yet when he has a chance to implement it, and a good chance to implement it, he is now taking steps to close these facilities—steps totally inconsistent with the thrust of that legislation.

Mr. KYROS. I want to commend you for bringing particularly to our attention these projects that are unique, because I think that they will certainly affect our judgment as to House Concurrent Resolution 98.

Thank you.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. No questions.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Sarbanes, for a very good statement.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Of course, we have had several other Public Health Service hospitals phased out over the years, have we not?

Mr. SARBANES. I understand we have.

Mr. CARTER. And this, then, is not an innovative thing? It is sort of a progression that started some time ago. I would like to ask you what was the census of this particular hospital during the past year?

Mr. SARBANES. The hospital handled 4,200 inpatients and 108,000 clinic visits.

Mr. CARTER. What percentage was the capacity of the hospital?

Mr. SARBANES. The inpatient capacity was about 77 percent I believe, but the hospital there as the hospital in Seattle, as indicated by Congressman Adams earlier, faced the problem of underfunding. It is very difficult to run at capacity if you are not given the money to start out with to run at capacity. Then you use a comparison which shows that you are falling short of capacity when you are not given the resources to be there to begin with.

Mr. CARTER. This occurs at all of the hospitals throughout our country, all of the Public Health Service hospitals. I believe average occupancy was about 70 percent, something in that area. Then, it seems that something should be done to utilize to its fullest extent these hospitals.

Actually, there was a loss there of 30 percent of the available beds. This has occurred throughout the entire Public Health Service.

Of course, there are certain programs here that are quite worthwhile, but again, as Dr. Egeberg stated, it is envisioned that these hospitals would become a part of health maintenance organizations which would really be consonant with the planning which has been made for this area. Perhaps that is the purpose of the administration at this time. It would certainly feel that the intention is not bad at all, but perhaps a more complete utilization of this facility.

Mr. SARBANES. I don't think anyone quarrels with a more complete utilization. The Congress passed the Emergency Health Personnel Act and that provides, it seems to me, the perfect vehicle to achieve that objective. To pass that legislation, broadening the function of the Public Health Service, and at the same time, to move in the budget to close out the hospitals and clinics, it seems to me is inconsistent.

Mr. CARTER. The very act you mentioned was actually to provide personnel for the rural areas and really didn't apply particularly to hospitals, did it?

Mr. SARBANES. You cannot provide high quality medical service to an urban ghetto area if you do not have the hospital as a backup facility.

Mr. CARTER. Of course, that is true, but if it is a health maintenance organization, it might provide even greater care, might it not?

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. No questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I have no questions. Thank you.

Mr. SCHMITZ. No questions.

Mr. ROGERS. I might say that during the Appropriations Committee hearings of last year, they noted declining patient load in some of the hospitals and the Public Health Service answers said one reason it was decreasing is that the length of stay has been decreasing.

In other words, they have been getting patients out of the hospital more rapidly, and secondly, that their ambulatory program, they are beginning to try to put greater emphasis on them to try to keep them out. They attribute this decreased hospital care to mainly those two points as well as the lack of funding to hire the necessary nurses and doctors to run it. Thank you. Your testimony has been most helpful.

Our next witness is Dr. John Chase, the Associate Deputy Chief Medical Director, Veterans' Administration, and Mr. Alfred T. Bronaugh, Associate General Counsel.

STATEMENT OF DR. JOHN CHASE, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY ALFRED T. BRONAUGH, ASSOCIATE GENERAL COUNSEL; AND RALPH T. CASTEEL, EXECUTIVE ASSISTANT TO CHIEF MEDICAL DIRECTOR

Dr. CHASE. Mr. Chairman, I would like to introduce the members at the table, Mr. Bronaugh on my right and Mr. Casteel on my left.

Mr. ROGERS. We are pleased to receive your testimony at this time.

Dr. CHASE. I have not brought with me a prepared statement but I would like to make a few introductory comments and will be glad to answer any questions.

The Chief Medical Director, Dr. M. J. Musser, has been unable to appear before the subcommittee today. He is at this moment testifying at the Appropriations Committee on our 1972 budget. I thought it would be helpful if I identified for you the chronology of our involvement in the subject matter of your hearings.

During the fall of 1970, Chief Medical Director, Dr. Musser, was contacted by a representative of the Department of Health, Education, and Welfare.

Mr. ROGERS. When was that, please?

Dr. CHASE. This was in the fall of 1970, and was in regard to the feasibility of the department of medicine and surgery of the Veterans' Administration assuming responsibility for some portion of the

primary beneficiaries of the Public Health Service Hospital System. This was then followed, in November, by an exchange of correspondence between HEW and the VA, at the top level, stating the conditions in which further discussions could take place.

Following this statement of conditions on the part of the Administrator of the VA and approval of these conditions by the Secretary of HEW, some preliminary meetings were held, but subsequent to that time, no further developments really have occurred.

In order to put this in the context of the VA ability to asume an additional load, I think you ought to realize we have had an increasing activity in the past year. This is predominantly because of increasing number of veterans brought about in large part by the discharges and the results of Vietnam conflict. This has meant that our bed capacity, which currently is at the level of 96,899 beds, is experiencing a patient load which in February was 87,716 patients.

This computes to an average occupancy rate of 90.5 percent. In addition to this, we anticipate that we will, in the coming year, receive applications for hospitalization at the level of 1.3 million applications.

Mr. ROGERS. What percentage would that be?

Dr. CHASE. Well, this is actually a head count, Mr. Chairman.

Mr. ROGERS. How does that compare with the present?

Dr. CHASE. It is an increase of about 5 percent over our current experience. As you are aware and have heard in previous testimony this morning, relative to occupancy rate, when a hospital system approaches occupancy rate over 90 percent, this is extremely tight and makes for difficult management decisions at a local level.

Should the VA be required to accept a new class of beneficiary for care, and under the current legislative authority, within which we operate, it would mean that these new beneficiaries would have to be placed in a priority for admission at lower level than veterans.

Probably these new beneficiaries would have very limited access to our system and only in facilities scattered geographically about the country.

This is a preliminary comment, Mr. Chairman. We would be pleased to answer any of your questions.

Mr. ROGERS. Thank you very much.

As I understand it, basically, what you are telling us is you would not presently be able to handle this additional load?

Dr. CHASE. We would find it very difficult.

Mr. ROGERS. And they would not be given priority of treatment, and there is no telling what their waits would be to get into a hospital for care. I assume there are currently waiting periods for those who have the primary call on the hospitals.

Dr. CHASE. We have a waiting list at the present time in our hospital system. It is small and differs widely, depending upon the geographic location of the veteran.

Mr. ROGERS. Could you let us have, for the record, the approximate cost of service, hospital cost for today's inpatient and outpatient?

(The following information was received for the record:)

1. Cost providing service to inpatients—

JULY 1, TO DEC. 31, 1970, PER DIEM COSTS—VA HOSPITALS

	Medical bed section	Surgical	Psychiatric
Direct care	$32.45	$39.38	$19.31
Support [1]	18.75	22.69	11.05
Total	51.20	62.07	30.36

[1] Administration, engineering, building management, research, education, and training.

2. Cost of outpatient visit. July 1, 1970 through December 31, 1970—Direct care: $17.71, service-connected outpatient care.

Mr. ROGERS. Have there been discussions about using some of the PHS hospitals for taking care of the overflow of Veteran hospitals?

Dr. CHASE. Not to my knowledge.

Mr. ROGERS. Would this perhaps be feasible in some instances where you have an overflow?

Dr. CHASE. Currently, our hospital system is capable of handling our load with minimum waiting requirements. Where we have the largest waiting list happens to be in San Juan, Puerto Rico. There are no Public Health Services in that locality to the best of my knowledge.

Mr. ROGERS. I assume, if Public Health beneficiaries came in, you might have to shift them all over the country, too.

Thank you very much.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

Dr. Chase, in Under Secretary Egeberg's statement before this committee on March 5, 1971, the statement with which you may or may not be familiar, I did not get the impression from Dr. Egeberg that if something did happen in the area, they could switch some of the patient load to VA hospitals. Is it a fact that the Health and Welfare officials had discussions with the VA as to whether you could pick up any of the caseload, either from hospitals or clinics that might be converted?

Dr. CHASE. Yes, sir; the original discussions contemplated this as one of the alternatives which they wished to examine.

Mr. KYROS. I presume you did not make studies in every region. Consider my own area of Maine. We have a Public Health Service Clinic in Portland, Maine, and we have a very fine Veterans' hospital in Togus, which is 60 miles to the north, close to Augusta.

You haven't made any studies as to whether the outpatient load from the clinic which they told us last Friday was 20,000 annual visits, could be picked up in part by Togus?

Dr. CHASE. I have some very preliminary figures which deal with this. I would hasten to add, though, that if this discussion were to proceed in any great depth, we would like to confirm these figures at a more specific level.

Mr. ROGERS. I think if the gentleman would permit, if you have figures that go to this for the areas where Public Health Service hospitals are located, or clinics, I think it would be helpful if you could submit those for the record.

Dr. CHASE. We would be glad to do that.

(The following information was furnished for the record:)

PUBLIC HEALTH SERVICE[1] AND VETERANS' ADMINISTRATION SELECTED DATA, FISCAL YEAR 1970

	Patient-days	Average daily census	Bed occupancy rate[2]	Outpatient medical visits	Outpatient dental visits
Alabama-Mississippi:					
PHS Clinic, Mobile, Ala.				11,132	3,502
VA Hospital, Biloxi, Miss.	229,950	630	95	17,936	889
California:					
PHS Clinic, San Diego, Calif.				3,690	1,067
PHS Clinic, San Pedro, Calif.				37,659	4,229
VAOPC, Los Angeles, Calif.				148,470	11,326
VAH, Los Angeles, Calif.	638,020	1,748	89	123,966	4,226
VAH, Long Beach, Calif.	534,725	1,465	94	122,317	3,966
PHS Hospital, San Francisco, Calif.	68,816	190		54,303	14,513
VAH, San Francisco, Calif.	95,265	261	82	72,087	8,605
Distict of Columbia:					
PHS Clinic, Washington, D.C.				406	146
VAH, Washington, D.C.	214,620	588	89	108,820	6,239
Florida:					
PHS Clinic, Jacksonville, Fla.				8,005	
VAH Lake City, Fla.	125,975	355	84	12,618	321
PHS Clinic, Miami, Fla.				7,233	1,784
VAH, Miami, Fla.	201,845	553	80	115,206	7,529
PHS Clinic Tampa, Fla.				6,658	1,721
VAH, Bay Pines, Fla.	240,535	659	100	92,739	9,054
Georgia:					
PHS Clinic, Atlanta, Ga.				120	46
VAH, Atlanta, Ga.	147,095	403	90	57,068	6,842
PHS Clinic, Savannah, Ga.				6,585	1,801
VAH, Augusta, Ga.	417,560	1,144	88	25,322	1,973
Hawaii:					
PHS Clinic, Honolulu, Hawaii				5,092	5,055
VARO, Honolulu, Hawaii				9,195	
Illinois:					
PHS Clinic, Chicago, Ill.				1,755	556
VAH, Chicago Ill. (WS)	173,375	475	94	119,561	9,174
VAH, Hines, Ill.	448,950	1,230	90	78,272	7,508
Louisiana:					
PHS Hospital, New Orleans, La.	45,410	125		39,146	6,264
VAH, New Orleans, La.	181,405	497	86	72,387	2,250
Maryland:					
PHS Hospital, Baltimore, Md.	16,920	46		13,687	3,233
VAH, Baltimore, tMd.	78,110	214	92	13,835	1,564
Massachusetts:					
PHS Hospital, Boston, Mass.	16,055	44		9,922	3,413
VAH, Boston, Mass.	242,360	664	90	56,165	4,885
VAOPC, Boston, Mass.				161,282	11,546
Maine:					
PHS Clinic, Portland, Maine				525	624
VAH, Togus, Maine	282,875	775	97	16,742	1,786
Michigan:					
PHS Clinic, Detroit, Mich.				1,158	1,654
VAH, Allen Park, Mich.	216,445	593	90	76,271	6,680
Missouri:					
PHS Clinic, St. Louis, Mo.				1,119	381
VAH, St. Louis, Mo.	146,365	401	85	74,919	1,617
New York-New Jersey:					
PHS Hospital, Staten Island, N.Y.	80,731	221		54,308	9,752
PHS Clinic, New York, N.Y.				39,551	16,551
VAH, Bronx, N.Y.	349,670	958	84	55,358	4,131
VAOPC, Brooklyn, N.Y.				93,414	7,555
VAH, Brooklyn, N.Y.	302,950	830	84	36,368	1,589
VAH, New York, N.Y.	331,785	909	83	214,778	15,544
VAH, East Orange, N.J.	308,060	844	86	99,577	7,884
PHS Clinic, Buffalo, N.Y.				1,119	509
VAH, Buffalo, N.Y.	289,080	792	93	70,330	7,741
Ohio:					
PHS Clinic, Cincinnati, Ohio				179	70
VAH, Cincinnati, Ohio	138,700	380	82	54,906	2,661
PHS, Clinic Cleveland, Ohio				2,177	682
VAH, Cleveland, Ohio	240,535	659	88	87,339	7,648
Oregon:					
PHS, Clinic Portland, Oreg.				3,581	750
VAH, Portland, Oreg.	160,965	441	87	54,956	4,716
Pennsylvania:					
PHS Clinic, Philadelphia, Pa.				11,643	1,533
VAOPC, Philadelphia, Pa.				109,219	8,236
VAH, Philadelphia, Pa.	157,680	432	86	31,115	1,434
PHS, Clinic Pittsburgh, Pa.				795	794
VAH, Pittsburgh, Pa. (Gen)	153,665	421	82	98,665	8,213
VAH, Pittsburgh, Pa. (Psy)	308,425	845	92	11,114	2,442
Puerto Rico:					
PHS, Clinic San Juan, Puerto Rico				5,331	920
VAH, San Juan Puerto Rico	77,745	213	85	97,286	3,416

See footnotes at end of table.

PUBLIC HEALTH SERVICE [1] AND VETERANS' ADMINISTRATION SELECTED DATA, FISCAL YEAR 1970—Continued

	Patient-days	Average daily census	Bed occupancy rate [2]	Outpatient medical visits	Outpatient dental visits
South Carolina:					
PHS, Clinic Charleston, S.C.				2,474	739
VAH, Charleston, S.C.	98,185	269	78	25,924	695
Tennessee:					
PHS Clinic, Memphis, Tenn.				5,599	1,257
VAH, Memphis, Tenn.	298,935	819	80	59,023	3,473
Texas:					
PHS Hospital, Galveston, Tex.	34,839	95		15,808	3,477
PHS Clinic, Port Arthur, Tex.				4,872	
PHS Clinic, Houston, Tex.				10,211	899
VAH, Houston, Tex.	386,535	1,059	92	85,592	4,987
Virginia:					
PHS Hospital, Norfolk, Va.	23,880	65		12,728	3,070
VAH, Hampton, Va.	179,945	493	91	19,025	2,487
Washington:					
PHS Hospital, Seattle, Wash.	23,498	64		22,765	6,590
VAH, Seattle, Wash.	97,820	268	91	52,576	5,133

[1] Primary beneficiaries, American Merchant Seamen.
[2] January 1971.

Mr. KYROS. Would it be all right if he discussed them right now, Mr. Chairman?

Mr. ROGERS. Certainly.

Dr. CHASE. Mr. Congressman, the listing which I have runs from Baltimore through West Roxbury, Mass., but does not include our facilities at Togus. So, we would have to provide this for you separately.

Mr. KYROS. Yes, sir. But Dr. Chase, I understand the thrust of your testimony is that VA facilities, with bed occupancy running what they are now, they would not be available to pick up much of the caseload in these other areas?

Dr. CHASE. Our capability would be very limited.

Mr. KYROS. What about the talk of the innovative programs that the Public Service hospitals were doing, cancer research, training 150 nurse's aides, medical librarians, do you normally pick up that kind of program?

Dr. CHASE. We have these programs in our hospital system. From the testimony which I have heard this morning, I would certainly have to agree, from what I have heard, we would classify these as innovative-type programs that are making contributions beyond the limits of the envelope of the hospitals.

Our ability to pick up these programs would have to be examined. Obviously, educational funds are limited. Our ability to support our own educational program, which constitutes about 50,000 trainees per year, does not contemplate picking up these other additional programs. The same could be said for research and clinical investigative programs.

Mr. KYROS. Thank you very much, Dr. Chase.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. Dr. Chase, you indicated someone from HEW made an inquiry as to whether the Public Health Service case load could be picked up by VA hospitals.

Dr. CHASE. Yes; an inquiry was made.

Mr. NELSEN. Based on that inquiry, you were assuming this was their plan. Aren't you overlooking the fact that certainly there is

nothing wrong in finding out if there is available space in Veterans' hospitals?

Dr. CHASE. There was no problem, sir, and I wish to correct my statement if there has been a misunderstanding. There is no problem in entering into discussions. These were carried on.

Mr. NELSEN. It seems to me that a good deal of the testimony we have received would indicate there is a bit of a desire to make it appear that with a bang the Public Health Service hospitals are to be closed. I have asked of Dr. Egeberg was this their intention if a need for these hospitals existed. The answer was "No." If you heard the testimony of Mr. Mitchell a moment ago, which was a very excellent statement, he pointed out what they have done in Baltimore to harness the facility to get it operating at nearly maximum capacity.

They have done an excellent job. This is what HEW is trying to do, to make these Public Health hospitals serve a community at capacity instead of a percentage to capacity, leaving a part of the hospital empty.

I would think this desire is something we should compliment. I, as a member of this committee would like to be sure that we do not close a hospital that is needed. I would also like to help HEW harness the total capacity and make it available to better serve a community. By doing this, the total costs would be reduced because the capacity of the hospital would be used.

I think we should direct our attention to this effort and in no case leave an impression we are trying to wreck them, because we will not permit that to happen.

I wanted to point out that actually there is nothing wrong with HEW asking VA if they had available rooms and I am sure that if the VA hospitals are overfilled, they could move some of these patients into the public service hospitals. I wanted to make that observation.

I am sure the point is well taken in your testimony. I thank you.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Dr. Chase.

I have no questions.

Mr. ROGERS. Mr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. Mr. Roy?

Mr. ROY. No questions.

Mr. SCHMITZ. No questions.

Mr. ROGERS. What is the average length of stay in the VA hospital? You may want to furnish this for the record.

Dr. CHASE. I would like to furnish the exact information for the record. We figure this on the basis of the percentage of our patients who were discharged within 30 calender days. If you look at our entire system, around 70 percent of our patients are discharged within a 30-day period. I do have to hasten to say, though, that about 40 percent of our beds are psychiatric. When you add this longer stay into the average statistics, it lengthens this period of stay.

Mr. ROGERS. If you could let us have a breakdown of the figures, I think this would be helpful.

(The following information was received for the record:)

Length of stay in VA hospitals—Calendar year 1969

Type of patient:	Days
Medical and surgical	26.5
Neurological	57.1
Psychiatric:	
Psychotic	451.0
Other	46.8
Pulmonary TB	136.5

Mr. ROGERS. Has it been proposed to close or decrease any VA hospital beds?

Dr. CHASE. No, sir. We have been required to close one hospital as a result of the California earthquake.

Mr. ROGERS. But the budget anticipated that?

Dr. CHASE. There are no closures contemplated.

Mr. ROGERS. I thought someone told us today you were closing one facility in Baltimore.

Dr. CHASE. I heard that statement made in the testimony. Sir, there is no plan to close any of the Baltimore area hospitals.

Mr. ROGERS. Is it reflected in any budget submission?

Dr. CHASE. No, sir.

Mr. ROGERS. Is your assumed patient load the same? I understood you were expecting an increase.

Dr. CHASE. If we project our current experience into the coming calendar year, we would experience actually about the same load that we have at the present time, simply because our occupancy rate in February is so high that I don't see how we could put many more patients in and continue to operate.

Mr. ROGERS. Then, your assumption of patient load is the same for the coming year as it has been?

Dr. CHASE. Except that budget hearings are going on now and we will have to wait and see what the budget hearings show in terms of our ability to operate.

Mr. ROGERS. Is this reflected in the budget request?

Dr. CHASE. The budget request to the congressional Appropriation Committee shows a projected occupancy rate of around 85 percent at a level of 79,000 census.

Mr. ROGERS. So the initial budget request does show a decrease?

Dr. CHASE. That is right. A decrease from our current operating level.

Mr. ROGERS. From your current operating level. That is what we thought.

Dr. CHASE. But there are no hospital closures contemplated.

Mr. ROGERS. But if you can't operate at current levels, there is a decrease of service available, isn't there?

Dr. CHASE. That is true, but the occupancy level is a comfortable occupancy rate for an active hospital.

Mr. ROGERS. I understand that. That is the way we would like all hospitals to operate. I thought your testimony is that you would be operating over that, really.

Dr. CHASE. If the pressure on our hospital system that we have right now, sir, and we had the capability of meeting the health care needs of those veterans that are exerting pressure for admission to our hospitals, we would expect in the coming year we will continue to

have something in the range of around 85,000 or 86,000 or 87,000 census rate on any given day in the hospitals.

Mr. ROGERS. Rather than the 79,000?

Dr. CHASE. That is correct. The 79,000 figure is a figure which is determined on 85 percent occupancy rate and the budgetary request is built upon that given level.

Mr. ROGERS. Your actual experience in February was 87,000?

Dr. CHASE. That is correct.

Mr. ROGERS. You have a little over 96,000 beds?

Dr. CHASE. Almost 97,000.

Mr. ROGERS. So that would get you up to what percentage of beds?

Dr. CHASE. In February, it was 90.5 percent occupancy rate.

Mr. ROGERS. And how are you going to pay for that?

Dr. CHASE. Well, if we get budgetary support at the level of 79,000, sir, then we will have to come back if we experience increased loads or we will have to limit operations at 79,000. The only other alternative is to reduce the quality of the care and that we will be very reluctant to do.

Mr. ROGERS. Either you will not admit people or else the budget has got to be changed.

Dr. CHASE. That is right, sir.

Mr. ROGERS. So, I don't see any possibility of coming in with additional load from some other source of beneficiaries.

Dr. CHASE. That is the way it would appear to us.

Mr. ROGERS. Thank you.

Mr. NELSEN. Mr. Chairman, the Budget Bureau does not make the appropriations, do they? Congress makes the appropriations based on the evidence that we get. The Budget Bureau projects a recommendation based on their information and we make the appropriations, the Congress of the United States.

Mr. ROGERS. Yes. They don't have to spend what we appropriate but we would hope that they would because I don't think the Congress is going to appropriate less than is needed for the health care. That is why we are having these hearings because I think there have been some budget decisions made in this decision and we want to air that fully and see if it can't be changed in a reasonable way.

Thank you. Your testimony has been most helpful.

Mr. ROGERS. Our next witness is Earl W. Clark, Labor Management Maritime Committee.

Mr. Clark, it is my understanding you would like to put your statement in the record and without objection this will be done.

STATEMENT OF EARL W. CLARK, LABOR-MANAGEMENT MARITIME COMMITTEE

Mr. CLARK. I thank the chairman.

My comments will be brief. I want to commend this committee and the Merchant Marine and Fisheries Committee for the initiative which they have taken in support of this cause. It was my privilege to open the testimony in the Merchant Marine and Fisheries Committee for the maritime industry and I am sure that testimony has been made available to this committee, so I shall not dwell on that nor plow the ground, Mr. Chairman, that has already been gone over.

I would like to have permission of the chairman and the committee to file in the record a position of the Propeller Club of the United States. I would request to do this on an informatory basis only. I say that because this is an organization that represents nationwide practically every segment of the maritime community, shipbuilding, ship operation, labor, management, everything in the maritime community is involved with this great organization, and they have taken what I consider a magnificent position on this subject and I have their authority to use it in any way and I should like to have it submitted.

Mr. ROGERS. Without objection, it will be made a part of the record at this point.

(The position paper referred to follows:)

THE PROPELLER CLUB OF THE UNITED STATES

POSITION NO. 5

SAVING THE PUBLIC HEALTH SERVICE HOSPITALS

Background

In December of 1970 the Secretary of Health, Education and Welfare indicated that the Administration was considering closing eight general PHS hospitals and some 30 out-patient clinics. This announcement charged inadequate quality of PHS hospital care and expressed an unwillingness to spend $140 million to modernize or replace existing facilities. In this is seen the strong hand of the Bureau of the Budget—for years the motivating force behind PHS hospital closings. The Bureau attempted to close these hospitals in 1965, but the Congress of the United States saved them and called for their modernization. Since then forces within government have sought their demise through attrition and disregard of Congressional intent. Any inadequacy in quality of care must be laid to this negative administrative practice. Now alleged inadequacy of care is being utilized as a further excuse to close the hospitals and clinics. The submitted budget for 1972 applies the meat axe to these hospitals, decreasing patient care allocations by $21.8 million and employment by $48.8. The budget would force hospital closing at Baltimore, Boston, Galveston, Norfolk, New Orleans, San Francisco, Seattle and Staten Island.

Meanwhile, national health care is one of the "Six Great Goals" in the President's 1971 State of the Union message. PHS hospitals should be utilized to achieve this goal. The fields of cancer research, drug addiction and scores of other areas of unmet national health needs call for expansion and modernization of these hospital facilities, not their elimination. Congressman Garmatz, Chairman of the Merchant Marine and Fisheries Committee of the House of Representatives, has introduced a concurrent resolution in the Congress, directed toward achieving such objectives. It deserves the support of all health-conscious citizens.

Position

The Propeller Club of the United States (1) deplores all attempts to close the Public Health Service hospitals in the face of the unmet health needs of the nation, including those of merchant seamen; (2) respectfully requests the President of the United States not to accede to such attempts within his Administration; and (3) fully supports the concurrent resolution now before the Congress in defense of these hospital services.

Mr. CLARK. Mr. Chairman and members of the committee, I am positive, in going over my statement, that I will be plowing ground that has been plowed here and I don't want to bore the committee with repetition. I testified yesterday at some length before the Subcommittee on Health of the Committee on Labor and Welfare in the Senate with Mr. Kennedy, chairman of that committee.

A development occurred there which I simply want to relate here. I am sure the committee, perhaps, is aware of this, but I should like to mention it as a part of my comments.

In my testimony before the Senate we associated ourselves somewhat with Mr. Nelsen's position in the sense that these hospitals should no longer depend solely on seamen. Actually, they haven't since 1913.

The committee will recall that before that time, they were called the Marine hospitals and as of that date, the name was changed to the Public Health Service title which it now has.

The reason that that titlization occurred was that they began to take in other types of beneficiaries, other than those purely of the seamen category. This has occurred over the years throughout a great part of this century so that while seamen hospitalization is cared for under title 42, in this great program, it is not the sole category. So, that the maximum use of these hospitals is the thing that is essential which I think is what Mr. Nelsen was getting at. We cannot understand as an industry why on the one hand, the Nation talks about a shortage of hospitals, a shortage of beds, doctors and nurses, and on the other hand, begins to talk about closing of the hospitals.

I understand they are moving a bit away from that term "closing", now. We think wherever health obligations of the U.S. Government are assumed by law or wherever these programs can be worked in to a full utilization of the hospitals, it should be done. This is no time for closing.

Let me turn to the point I started to raise earlier. It was my understanding in listening to the testimony in the Senate yesterday, and I listened to Dr. Egeberg there—I did not hear him, Mr. Chairman, before this committee—but yesterday I understood from him that the current movement now is a movement to try to turn the hospitals over to State and local communities.

It has been my experience from what I have read and heard that the cities are in bad shape. Some of these cities are crying about almost a state of bankruptcy. I don't understand how you can turn these hospitals over to State and cities in that condition and expect them to take over.

I think what would happen in this instance, if that occurred, is that the money that would be required again would come from the Federal Government, so in either case, you would have a financial situation which would call for some underwriting by the Federal Government.

Most of the witnesses that I heard yesterday testified against that proliferation, if you will, in this whole program. You might as well keep it where you have it. But one further point, and then I am finished. The question was raised at one point as to whether the legal responsibility of the Federal Government to maintain a system—and that is the reading of the law, to "maintain a hospital system"—is met under such a circumstance where it is turned over to the cities.

Would that be maintaining a system? Of course the answer came as I got it that, well, the Federal Government would have an involvement in it in the sense that it would put up money and it would have some supervisory control over the type of beneficiaries, particularly the primary types, for which by law, they have authority.

Then that raised the question, again, as I recall and as I understood the testimony, as to whether legally this met the provisions of law and it was the decision of the Chair in the Senate—the Subcommittee on Health—that that question be referred to the Comptroller General.

So, here is an ancillary item, if you will, legalwise, that may go to the Comptroller General, again, now, from the Senate side. I compliment the House of Representatives and the committees that are involved in it for having referred a related question to the Comptroller General previously.

Mr. Garmatz was quite wise in doing this. It was done in 1965 with similar results. If you are not alerted to this new Senate development, and I assume you all are, I want to make the point here because this is a new development which may hit here and there in the whole gamut of treating of this problem.

I think with that, Mr. Chairman, I will conclude by saying that I know of no issue that has risen in recent years in which, in the maritime community, there is such complete unanimity.

You know, sometimes labor has difficulties with labor, management with management, and sometimes management with labor. But there is absolutely a uniformity in the maritime community throughout the country in supporting the hospital system as it is now.

I thank you for letting me make these comments.

(Mr. Clark's prepared statement follows:)

STATEMENT OF EARL W. CLARK AND HOYT S. HADDOCK, CODIRECTORS, LABOR-MANAGEMENT MARITIME COMMITTEE

Mr. Chairman and members of the committee: We appreciate the opportunity to submit this statement of the Labor-Management Maritime Committee with reference to Concurrent Resolutions in the House of Representatives directed toward saving the U.S. Public Health Service hospitals.

The Labor-Management Maritime Committee, composed of major steamship lines and seagoing unions, has long supported the U.S. Public Health Service hospital program, including its marine hospitalization services.

In connection with the current hearings, the Co-Chairmen of our organization, Mr. Joseph Curran, President of the National Maritime Union, and Mr. Spyros S. Skouras, President of Prudential-Grace Lines, speaking for our Governing Body, have directed that full support be given not only to the retention of the PHS hospitals but also their modernization as well.

We have taken full note of the Concurrent Resolution introduced by the Honorable Edward A. Garmatz, Chairman of the Merchant Marine and Fisheries Committee of the House of Representatives and joined by other members of the House of Representatives. We wish to support wholeheartedly this entire movement sponsored by so many Members of the Congress.

In 1798 when the first "marine" hospitalization act was enacted, the beneficiaries were seamen only. This is no longer the case and has not been for most of the twentieth century. Beginning in 1913 and thereafter, beneficiaries have also included recipients in the non-seamen categories. In fact, it was about that time that the name of the hospitals themselves was changed from "marine hospitals" to "Public Health Service Hospitals" in recognition of this fact. Subsequently, the marine hospitalization program became only one of several categories of beneficiary care, although it remained a major one. The Federal responsibility for seamen's medical and hospital care in the Public Health Service Hospital program is a matter of law fully enunciated and vividly interpreted in a ruling by the Comptroller General on June 7, 1965, and recently reaffirmed by Comptroller General Elmer B. Staats on February 23, 1971.

We hold, therefore, that the continued efforts of the Bureau of the Budget and the Department of Health, Education and Welfare are not keeping with established law enacted by the Congress of the United States but rather in direct conflict therewith. Yet these agencies have persisted in disregard for both the letter and the spirit of long-standing legislative enactments.

Aside from the legal aspects, there appears to be a real contradiction in the current approach to national health problems by the particular agencies now seeking elimination of the PHS hospitals. On the one hand is a national recognition of the need for greater governmental involvement in improving the nation's health. One of the six great goals in the President's State of the Union message

was improvement of national health care. On the other hand, certain government agencies proceed toward the closing of badly needed facilities in the face of recognized nationwide shortages of beds, nurses and available hospital services. This is a dichotomy of the first magnitude.

The Public Health Service Hospital program should be enlarged. The services should be expanded and the facilities modernized, as is called for in the Garmatz proposed Concurrent Resolution. The field of cancer research, as portrayed in the President's State of the Union message, is one to which the PHS hospital program could address itself. Drug addiction is infesting the health of large numbers of our citizens and needs more direct and responsible attention. These two citations are in no way limiting. The Public Health Service should be given broad responsibilities in these and other areas of national health need. It makes little sense to eliminate a ready and going hospital system like that of PHS when we know other hospitals will have to be created to handle these unmet needs.

After the PHS hospitals were saved by Congress in 1965, the order of the day was to expand and modernize them. This was never done and did not get beyond the drafting stage. The reason was clear and evident. The same government agencies that today advocate their closing made little effort to carry out the will of Congress and, in fact, dragged their feet, permitting attrition and neglect to further deteriorate the facilities and the general program. They now use the very "deteriorated" condition they helped create as a justification to close the hospitals and thus achieve the original goal they espoused. Nor was the Congress apparently even consulted in current efforts to close them.

The Labor-Management Maritime Committee is not without knowledge of the developments in this area. In 1964 it published a two volume book entitled "Medical and Hospital Care for Merchant Seamen" with which many members of the Congress are familiar. It was used widely in testimony before the Congress in 1965 in opposition to a similar threat to close out the PHS general hospital system at that time. We hold that our position in support of the PHS hospitals then is equally valid today.

We have heard that competent medical staff has left the PHS hospital program due, in a very real sense, to the permitted deterioration and overall disregard for improvement in the hospital facilities. Surely the constant uncertainty as to the future status of these hospitals has not only caused many professional staff members to leave but also mitigated against prospective staff members aligning themselves with the program. This is an unhealthy condition and should be stopped.

It is time for the Congress to insist that its will be carried out: that the PHS program be increased to help provide for the unmet needs of the nation: that the PHS hospital facilities be modernized and the services themselves expanded. We urge this Committee and the Congress as a whole to adopt an appropriate Concurrent Resolution to save these hospitals.

We particularly favor the language of the Resolution proposed by the Honorable Edward A. Garmatz and those submitting identical proposals.

We respectfully request that this statement be made a part of the record of the hearings.

Mr. ROGERS. Thank you, Mr. Clark. We appreciate the advice you have given the committee and the information.

Mr. Kyros?

Mr. KYROS. One or two questions, Mr. Chairman.

Mr. Clark, among the other points which you brought out here and also the letter sent out, dated December 21, 1970, which I thought was a very comprehensive statement of the problem, isn't it a fact that we are planning embarking hopefully on a program of building 30 merchant ships a year for a total program of 300 ships?

Mr. CLARK. Yes, Mr. Kyros, that is a very important point, and we have called this perhaps for the want of a better term, a dichotomy, in the whole situation because on the one hand, we are going to build up the Merchant Marine and that has been the intent expressed by the Congress in voting in the Maritime law of 1970. We are at that now, we are moving toward it, and the Congress has sort of laid down the

premise and supported it by active legislation that we are going to build a strong Merchant Marine.

That means more seamen and when they talk about the seamen's caseloads continuing to deteriorate, I have two answers to that. I think it will not continue when we get our Maritime program underway, which is the point I am making in reference to your question.

The second thing is that the hospitals have not been solely dependent on seamen since 1913 anyway. It is also supposed to meet other health needs of the Nation as provided in the format under which those hospitals now operate.

Mr. KYROS. Certainly, to its credit last year, the administration put its full weight behind this 30-ship program.

Mr. CLARK. It did indeed, yes, sir.

Mr. KYROS. The Congress then joined in and we were all together in this. If we are going to go forward, it seems we would not cut medical and outpatient facilities for seamen along with other things at this time.

Mr. CLARK. We aline ourselves with your position entirely.

Mr. KYROS. I come from the New England coast and we have problems there today with our young men going to sea in fishing vessels. We see foreign vessels with trained men out there fishing right off our coast day in and day out. I understand the Public Health Service hospitals also serve fishermen, so, won't it again be another harmful gesture toward an industry which we want to promote? And we must promote it if we are to survive.

Mr. CLARK. I agree with you.

Mr. KYROS. Thank you for your statement.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Carter?

Mr. CARTER. I wonder what percentage of the beds in the Baltimore hospital are used by merchant seamen?

Mr. CLARK. Sir, I entered into the record in the Senate yesterday those figures. I did not bring them this morning with me, but if it would be helpful to the committee, I would be happy to enter that as part of the record. I have it not only for Baltimore but for all of the hospitals.

Mr. ROGERS. That would be helpful. Without objection, that will be made a part of the record.

(The following information was received for the record:)

AMERICAN SEAMEN

Hospitals	ADPL		Out-patient visits	
	1969	1970	1969	1970
Baltimore	63	52	17,507	18,162
Boston	46	44	12,633	13,335
Galveston	96	96	18,818	19,285
New Orleans	200	195	45,559	45,410
Norfolk	57	65	15,419	15,800
San Francisco	188	177	68,189	68,812
Seattle	77	64	29,323	29,346
Staten Island	277	219	66,835	63,777
Total all hospitals	1,004	912	274,289	273,927

AVERAGE DAILY PATIENT LOAD (ADPL), HOSPITALS

	1969			Comparison
	Seamen	Non-seamen	1969 total	1970 total
Baltimore	63	134	197	172
Boston	46	69	115	126
Galveston	96	26	122	125
New Orleans	200	112	312	307
Norfolk	57	70	127	142
San Francisco	188	81	269	250
Seattle	77	121	198	180
Staten Island	277	203	480	420
Totals all hospitals	1,004	816	1,820	1,722

OUT-PATIENT VISITS TO ALL HOSPITALS IN 1970

Hospitals	Seamen	Non-seamen	Total	1969 comparison total
Baltimore	18,162	78,447	96,609	87,793
Boston	13,335	45,027	58,362	56,175
Galveston	19,285	25,992	45,277	43,632
New Orleans	45,410	100,037	145,447	138,447
Norfolk	15,800	77,185	92,985	85,704
San Francisco	68,812	49,762	118,574	110,957
Seattle	29,346	82,774	112,120	103,128
Staten Island	63,777	79,029	142,806	137,973
Total, all hospitals	273,927	538,253	812,160	763,809

RECAPITULATION

	1969	1970
American seamen:		
ADPL (hospitals)	1,004	912
Outpatient visits	274,289	273,927
Seaman and nonseamen: ADPL (hospitals)	1,820	1,722
Seamen and nonseamen: Outpatient visits to all hospitals	763,809	812,180
Total for all 30 outpatient clinics	[1] 799,483	[2] 82,635

[1] Seamen, 235,777; nonseamen, 563,706.
[2] Seamen, 229,274; nonseamen, 591,361.

Mr. CARTER. Would it be one-half, do you think?

Mr. CLARK. I would guess one-half.

Mr. CARTER. Would it be approximately; I believe the occupancy was stated to be about 70 percent. About half of that would be seamen.

Mr. CLARK. Yes. I did a two-volume book on the subject and I think Mr. Rogers has it, and when we surveyed the hospitals with the permission of the Comptroller General in 1965, at that time seamen were in some of the hospitals and I believe Baltimore was in excess of that.

Some of them were a little bit below it. But it would rank in that area, I think.

Mr. CARTER. Of course, when these hospitals were formed, they were not only for our seamen but for seamen of foreign governments, too.

Mr. CLARK. Not quite so, sir; if I may comment on that.

Mr. CARTER. Yes, sir.

Mr. CLARK. The law of 1798, as originally, I think I am correct in this, contemplated American seamen, but the foreign seamen were added at a later date, but they have beneficiaries in these hospitals for

many, many years. They fall under a little different category. They pay, you see.

Mr. CARTER. But they are entitled to admission.

Mr. CLARK. Yes, sir; they are entitled to admission.

Mr. CARTER. No more questions, Mr. Chairman.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. No questions, thank you, Mr. Chairman.

Mr. ROGERS. Mr. Roy?

Mr. ROY. No questions.

Mr. ROGERS. Thank you very much. We appreciate your testimony.

The AFL–CIO has a statement they would like to present for the record and it will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT OF JOSEPH CURRAN, CHAIRMAN, AFL–CIO MARITIME COMMITTEE

My name is Joseph Curran. I am President of the National Maritime Union of America, AFL–CIO, and Chairman of the AFL–CIO Maritime Committee.

The AFL–CIO Maritime Committee consists of the following unions:

National Maritime Union; National Marine Engineers' Beneficial Association; International Longshoremen's Association; International Organization of Masters, Mates and Pilots; American Radio Association; and United Steelworkers of America.

Mr. Chairman, we support House Concurrent Resolutions No. 149 through No. 156 and 177, all of which are identical. These resolutions have Congressional intent of keeping open the Public Health Service hospitals. Despite our intention to be as brief as possible, for clarification purposes, we will be compelled to repeat some of the arguments already presented to you.

We thank and commend the 200 plus Congressmen who co-sponsored all of the House Concurrent Resolution.

We have requested Senator Edward Kennedy and his Senate co-sponsors of Senate Concurrent Resolution No. 6 to consider modification of the "resolve" language starting on line 5 of page 3 of Senate Resolution No. 6 which states, "During this interval, the Secretary and the Congress should explore the resources and capabilities of these facilities in their communities, to determine which facilities should continue to be operated by the Public Health Service, which facilities should be converted to community operation, and which facilities, if any, should be closed." We understand the importance of this intent but we prefer the more direct wording of House Concurrent Resolution No. 149 introduced by Congressman Edward Garmatz and co-sponsored by 194 Representatives in the House. The stronger language of the House concurrent resolution is as follows:

> "* * * the Public Health Service hospitals and outpatient clinics not only remain open and funds be made available for the continued operation of such hospitals and clinics, but that additional funds be made available for the modernizing, upgrading, and expanding of all existing facilities in order to properly carry out the responsibilities of the Public Health Service to provide the best medical care and treatment to beneficiaries entitled thereto under the law."

As a brief background we observe that the Public Health Service Hospitals came under attack during the opening days of each new Administration. Despite the program's origin back to 1798, the Bureau of the Budget in the past and the Office of Management and Budget today seem to find some strange reasons to keep up their attacks on this great program.

The Public Health Service hospital system has provided medical care for merchant seamen, Coast Guardsmen, and other beneficiaries for many years. This system has been tested for 173 years and passed the tests with adequate testimonials to its great work in helping to protect our nation against imported disease catastrophes. Furthermore, it has established and maintained a public service concept that has benefitted the medical profession by providing good training to young medical and dental professionals.

The highest number of PHS hospitals was thirty (30) which were scattered throughout our nation's seaports and inland waterways. These hospitals were decreased in number until today we have eight as follows:

Hospitals:	*Number of beds*
Staten Island	636
New Orleans	403
San Francisco	366
Seattle	281
Baltimore	238
Norfolk	210
Boston	190
Galveston	160

Also, there are 30 PHS Clinics located in Mobile, Ala.; San Diego and San Pedro, Calif.; Jacksonville, Miami and Tampa, Fla.; Atlanta and Savannah, Ga.; Honolulu, Hawaii; Chicago, Ill.; Portland, Maine; Detroit, Mich.; St. Louis, Mo.; Buffalo and New York, New York State; Cincinnati and Cleveland, Ohio; Portland, Oreg.; Philadelphia and Pittsburgh, Pa.; Charleston, S.C.; Memphis, Tenn.; Houston and Port Arthur, Tex.; Washington, D.C.; and San Juan, Puerto Rico.

As we stated, the Public Health Service hospitals and clinics provide care not only to merchant seamen but to Coast Guardsmen and their dependents as well as to active and retired military personnel and their families.

Congressman Paul G. Rogers (D–Fla.) has observed that the total inpatient and outpatient care of the 8 hospitals and all of the above outpatient clinics was over 1.7 million cases last year.

The AFL–CIO Maritime Committee listened intently to President Nixon's December 10, 1970 press conference. We heard the President emphasize that he was preparing the start of his Administration's attempt to solve the twin problems of health care in America which are:

1. The escalating costs for doctors, drugs, and hospital care that now cost Americans some $70 billion a year. This staggering cost, last year, increased 16 percent which is far sharper than our general inflationary trend in the United States.

2. The poor state of the nation's health which exists despite our heavy and sharp cost increases. Thus, among industrialized nations, America today ranks 13th in infant mortality, 18th in life expectancy for men and 11th for women. It was emphasized that Americans today are less healthy than they were 20 years ago.

The Administration has now presented its health proposals to the Congress of the United States. At this time we would prefer not to discuss the many facets of the health programs on which Congressional Committees are holding hearings. However, we cannot separate the Public Health Service Hospital system from the overall health programming for our nation.

In solving the current shortage of hospital beds in our nation, the Public Health Service hospital system provides some 2,500 beds. The system is staffed by 5,300 people with an annual budget of approximately $70 million. In addition to the nearly 300 physicians, dentists and interns in training, the system provides employment opportunities and training to nurses, dieticians, specialized medical librarians, X-ray technicians, and pharmacists. Also, approximately $6 million a year is invested in research programs.

Those who call for closing the PHS Hospital system state that there is an under-utilization of the current facilities and that merchant seamen, Coast Guardsmen, and other PHS beneficiaries would receive greater benefits at other community facilities or at the Veterans Administration facilities. These are not facts.

Congressman John Murphy, who has the Staten Island hospital in his Congressional District, made a pertinent and telling observation during the recent hearings before the House Merchant Marine and Fisheries Committee. He picked up Secretary Richardson's remark that:

> "* * * taking the eight hospitals as a whole, the average rate of occupancy is 70 percent, which is comparatively low as hospitals go today * * *"

Congressman Murphy countered this charge with the following:

"Mr. Secretary, your largest facility is the Public Health Service Hospital at Clifton, Staten Island. It is true that its occupancy based on its old rated bed capacity is a low rate, lower than 70 percent you just mentioned; but your Department has only staffed this hospital for about a 410 bed usage, which is 65 percent. Now the hospital would be utilized at a hundred percent of bed capacity had the Department staffed it for a hundred percent bed capacity. It is staffed for 65 percent so it is operating at 100 percent of its staff capacity."

We have been claiming for years that the Public Health Service Hospital system, as any institutional system, will provide the quantity and quality of services for which it is budgeted. This is especially true where there is a need for a service such as health care.

Another misstatement is that the merchant seamen who use approximately fifty percent of the PHS system and the other beneficiaries using the other 50 percent could be adequately cared for in other community hospitals and Veterans Administration hospitals.

There is little necessity to repeat the many observations of the nationwide shortage of hospital beds in American communities both in cities and in rural areas. Also, it is well-known that the Veterans Administration hospitals have long wartime lists and are now appearing to feel budgetary pinches which are resulting in inadequate care in too many cases.

The veterans organizations strongly support the Public Health Service Hospital system. They acknowledge the need for this system which should continue to be supported and not curtailed.

Our nation and, in fact, all nations bounded by oceans, are facing a great future in the oceans and on the ocean bottoms. Oceanography and aquaculture will provide great resources needed by all mankind. These observations are not ours alone. They have been stated and restated by those agencies of the Executive Branch of our Government and the pertinent Congressional Committees. In fact Congressman Jack Brooks of Texas recently pointed out to the House Merchant Marine and Fisheries Committee:

"Now the Marine Biomedical Program, one of the leading edges of this facet of human knowledge, is being installed in Galveston now, a fifty to sixty thousand dollar decompression chamber, in connection with the auspices of the University of Texas Medical Branch there in Galveston. The Public Health Service has assumed the responsibility for underwater casualties. We have considerably more underwater activity in the Gulf than we do elsewhere on the other coasts of this country. This will be a facility that will lead the way in how to take care of underwater casualties.

"There are now 25 beds already set up for such care that is now proposed. They have a training program in conjunction with the University trained doctors and personnel who work with the Public Health Service in an effort to save these people."

Congressman Brooks then made the important conclusion as follows:

"That hospital (at Galveston) was built about 35 years ago to house 79 patients. It now has 160 patients. It has a steady use and need for 200 beds at all times. I would say that rather than closing Galveston, the hospital needs replacement . . . The need for this new hospital has been demonstrated. The wisdom of this investment in health services to our area is plainly evident. The dividends that will be paid by its association with the University of Texas Medical Branch will be astronomical and continued delay can only result in losses of medical training and services on the same order."

There is no doubt that the need for marine hospital specialization will grow greater when aquaculture, in the form of three-dimensional farming in the oceans, takes people deep into the ocean waters. The health needs of the pioneers who will venture into the ocean depths must be met by an organized medical program. This program is already in existence and must be expanded to meet these current and future requirements.

We cannot conclude our statement without the observation that Congress, in its wisdom, has provided a Public Health Service hospital system. This wisdom is again and again pressed on by budget personnel who seem to ignore the needs of our nation which are clearly spelled out.

In 1965 the Comptroller of the United States had ruled that the Public Health Service Hospital system could not all be closed by administrative actions. Recently this was confirmed firmly and conclusively by Comptroller General Elmer B.

Staats in an 8-page letter to Congressman Edward Garmatz which rules that the Administration does not have the authority to close all the hospitals in the PHS system. The key word is all, but he makes it plain that Congress passed a law in 1798, amended this law several times favorably, and that the Executive Branch has no authority to operate contrary to this law. He also states in his letter that PHS patients may be referred to facilities other than PHS only when there is an overflow of patients in the PHS system or if the nearest facility is remote in distance to the beneficiary needing care.

We shall not attempt to present all of our arguments in favor of not only retaining but expanding and improving our Public Health Service hospitals and outpatient clinics. We know that this great Congressional Subcommittee is quite aware of the medical and health needs of our nation. We have faith in your knowledge and wisdom that created this important system in 1798 and kept it in existence to date.

We thank you for the opportunity of presenting to you the views of the great majority of our nation's maritime workers. We respectfully ask you to support the House Concurrent Resolutions introduced by Congressman Edward Garmatz, Chairman of the House Merchant Marine and Fisheries Committee and the 194 co-sponsors of his No. 149 and identical House Concurrent Resolutions.

Mr. ROGERS. This concludes our witnesses for this morning and the committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 11:50 a.m., the hearing adjourned to reconvene at 10 a.m., March 10, 1971.)

OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

WEDNESDAY, MARCH 10, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a. m., in room 2325, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing our hearings on resolutions to express the sense of the Congress that the Public Health Service hospitals not be closed.

Our first witness this morning, one of our colleagues, who we are delighted to welcome to the committee, the Honorable Jack Brooks of Texas, who has been very interested in this matter and has followed it very closely, and the committee will be pleased to have you present testimony at this time.

We are honored to have you.

STATEMENT OF HON. JACK BROOKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BROOKS. Thank you very much, Mr. Chairman.

May I first say, the people of this country and the Members of the Congress who represent a portion of them, are deeply grateful for the effort you and your subcommittee has made to see that we continue to have the Public Health hospitals in his country, as the law requires, and as conscience also requires.

Mr. Chairman, the recent report issued by the Comptroller General, advised that the Department of Health, Education, and Welfare does not have the authority to close Public Health Service hospitals. Although this statement of Federal responsibility should put an end to efforts to close Public Health Service hospitals, I am still apprehensive in that the 1972 budget does not include funds for the continuing operation of eight of these hospitals, including the one in Galveston, Tex.

It seems to me that the absence of budgeted funds is clearly a threat to the intent of Congress that these hospitals should continue to serve their statutory functions. This should be both alarming and distressing to every American concerned with the health crisis now confronting our Nation. But it should not come as a surprise—for, clearly, the Nixon administration has an ill-conceived sense of national priorities when considering the human needs of our people. Throughout our Nation, we need more facilities, better facilities, more doctors, and bet-

ter care, no reasonable pension can suggest that this will be provided by closing existing medical facilities.

The Public Health Service hospital in Galveston has a treatment jurisdiction covering an area on the gulf coast from Cameron to Brownsville, Tex. It has satellite clinics in both Port Arthur and Houston which provide outpatient service. Those receiving treatment include maritime personnel, active duty military personnel and their dependents, and retired maritime personnel.

Together, there are over 6,000 primary statutory beneficiaries, and over 50,000 secondary beneficiaries served by the Galveston Public Health Service Hospital. Obviously, not all of the potential patients actually become patients in any given year in the clinics or the hospital. However, last year, the hospital admitted over 2,500 inpatients and outpatient visits totaled 43,630.

Through its close affiliation with the University of Texas Medical Branch, the Galveston Public Health Service hospital provides medical training for both students and doctors in residency. The medical schools' departments in surgery, dermatology, otolaryngology, ophthalmology, and marine biomedical institute have "affiliation agreements" with the U.S. Public Health Service wherein Public Health officers are appointed to the faculty of the school of medicine and members of the faculty serve as consultants to the Public Health Service. Through the years, this joint endeavor has resulted in the very best patient care, teaching, and research.

I might add that I have had a minimum of complaints from patients, practically none. They like the service. They appreciate it.

At a time when all Americans are demanding better health care, I can find no reason why this facility and others like it throughout the Nation should be closed. And yet, this is what the Nixon administration proposed to do.

Mr. Chairman, if we are to continue to fight for better health for all Americans, then we must do everything in our power to prevent the closing of these vital facilities. We should do this and much more, for studies—the studies that they have been sitting on—the studies clearly indicate that rather than closing Public Health Service hospitals, we need to build new modern hospitals with greater capacity and the best possible equipment to provide the medical care that is so thoroughly needed.

I want to thank you again for the opportunity to testify and again commend your committee and your subcommittee for the great work they are doing. Our real thrust is not only to keep the pressure on this administration but to see to it that they either submit a supplemental budget request for the money to do this job, or we will institute such action in the Committee on Appropriations and appropriate the money.

I believe this Congress will, without question, appropriate the money to maintain and improve these hospitals, and we are going to have to do that. They can either do it themselves or we will have to institute that kind of a motion, either within the Appropriations Committee or do it on the floor, when they bring the bill out and get it locked into that bill.

Thank you, sir.

Mr. ROGERS. I appreciate very much your testimony, and I agree with you that unless the administration comes forth very quickly with

the necessary supplemental request, that we are going to have to take that action.

Of course, in these hearings, we hope we are laying the foundation to do some of that.

I think it is interesting to note that when he had gotten the report of the survey teams that when out, after the budget was already submitted with no money, then they sent survey teams out to see what they should do. There is no recommendation that any of these hospitals be closed from the survey team set up by the Department of HEW.

Mr. BROOKS. Even their own people didn't recommend it.

Mr. ROGERS. Yes, sir.

Mr. Roy?

Mr. ROY. I want to thank my distinguished colleague for that excellent testimony.

I have no questions.

Mr. ROGERS. Mr. Schmitz?

Mr. SCHMITZ. I have no questions.

Mr. ROGERS. Thank you very much.

Mr. BROOKS. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is the Honorable F. Edward Hébert, the distinguished chairman of the Committee on Armed Services. Welcome, Chairman Hébert, it is a pleasure to have you with us this morning.

JOINT STATEMENT OF HON. F. EDWARD HÉBERT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA, AND HON. HALE BOGGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. HÉBERT. Mr. Chairman, first of all I would like to say that my colleague Congressman Hale Boggs concurs in this statement and we are grateful for the opportunity to offer our views regarding the U.S. Public Health Service Hospital system and particularly the essential role it plays in our own community, the city of New Orleans.

We have carefully read the statement delivered to this committee by the Honorable Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare.

We are confident that the Congress and the cities concerned will be kept abreast of HEW's actions in regard to Public Health Service hospitals. It is inconceivable to us that the closing of Public Service hospitals could be seriously contemplated in these days of a serious hospital bed shortage and an oncoming crisis in health care.

The decision of the Comptroller General that HEW does not have the authority to close PHS hospitals was noted with interest. We are hopeful that any thoughts aimed at closing these facilities have been abandoned.

It has been stated before this committee that PHS hospitals are not being utilized to maximum capacity. We believe the reason for this is the fact that the hospitals are understaffed and unable to efficiently accommodate a larger patient load. Similarly, some of the facilities are in bad physical condition, but dereliction in keeping

them modern should not now be used as a reason for closing these hospitals.

The U.S. Public Health Service has maintained a medical facility in New Orleans since 1802 when Congress appropriated $3,000 to provide medical care for American seamen. Since that time, with the exception of the years of the Civil War the Public Health Service Hospital has been an essential health care institution for our community and for our region.

Today, the New Orleans hospital is one of eight general medical-surgical hospitals located in port cities around the country. The facility now serves Missouri, Arkansas, Louisiana, Tennessee, Alabama, Mississippi, Florida, and the Panama Canal Zone. It operates clinics in St. Louis, Memphis, Mobile, Tampa, Jacksonville, and Miami. In addition there are 20 outpatient offices and 20 other areas within the district where medical services are provided.

In addition to providing comprehensive medical care for American merchant seamen, the New Orleans facility now treats Federal employees injured on the job, members of the uniformed services.

The result has been that today the Public Health Service hospital in New Orleans is a vital part of our community's health care complex.

During the past year, the hospital's outpatient load was more than 140,000 visits and its average daily inpatient load was 320.

Each year the facility trains 18 medical interns and six dental interns. At present, its residency staff numbers 34 physicians in a variety of specialties. Many of these staff members have appointments with our two medical schools and other departments of our universities. At present the hospital is a partner in a number of joint research and training and treatment programs with other health care institutions in our community, including among other things a 24-hour-a-day Poison Control Center; a Preventive Medicine Clinic, which screens welfare personnel for Total Community Action; the New Orleans Office of Economic Opportunity organization; and a six-bed renal dialysis unit which, on occasion, has kept patients alive when other community facilities were not available.

These are not the signs of an institution which has outlived its usefulness. These are the signs of a vibrant and innovative health care facility. We believe the New Orleans Public Health Service hospital is performing an essential function in our community. In addition to fulfilling its primary role of rendering comprehensive health care to merchant seamen, fishermen, and members of the uniformed services, it is demonstrating that a Federal medical installation has something to contribute to a community, that it can make its contribution without encroaching upon the private sector of medicine, and that all segments of a community can gain from its participation.

The U.S. Public Health Service hospital has become an essential component of our community's medical complex.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Mr. Hébert, for a very thoughtful statement. The committee appreciates your interest in this important legislation.

Mr. HÉBERT. Thank you, Mr. Chairman, for affording me the opportunity to be here this morning.

Mr. ROGERS. The Honorable William S. Mailliard, of California, has a statement he would like to present to the committee this morning. Welcome, Mr. Mailliard, proceed as you see fit.

STATEMENT OF HON. WILLIAM S. MAILLIARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. MAILLIARD. Mr. Chairman, I appreciate the opportunity to join my colleagues in presenting a statement for the record on the continuation of the Public Health Service hospitals and outpatient clinics. Today's hearings are of special import to me as a PHS facility is located in the Sixth District of California, which it is my privilege to represent.

I have introduced a resolution that not only opposes the proposed closure of Public Health Service hospitals and clinics, but encourages amplification of various facilities and services. For it is my conviction that they can further the President's goal of improved national health care.

Our entire medical system is now dangerously overstrained. Elimination of PHS facilities will intensify, not alleviate this strain. PHS hospitals and clinics are vital to the total supply of medical resources. Their potential should be recognized and utilized.

The PHS is also authorized to serve communities where a particular seamen, Coast Guardsmen, PHS employees, their dependents, and those of retired military personnel since 1798. If PHS facilities are closed, the half a million patients treated in 1970 will have to turn to already overcrowded, understaffed private and Federal institutions. Medical care will become less accessible and more expensive for them.

The PHS is also authorized to serve communities where a particular need is indicated. And there are urgent needs in the depressed urban and rural areas where many PHS facilities are located. The possible contribution of the PHS to inhabitants of these sectors is suggested by recently innovated PHS programs: a drug and alcoholic detoxification center; family planning clinics; a training program for Neighborhood Youth Corps volunteers.

Patient potential and requirements exist. Space exists. What is needed is a positive attitude toward PHS facilities and programs: an attitude, and action, that will stimulate the expansion of the vital aspects of these medical resources and integrate them into the total health care system.

It is my hope that these hearings will shed light on the dire need for the continuance of Public Health Service hospitals and outpatient clinics.

Mr. ROGERS. Thank you Mr. Mailliard, for sharing your views with us today.

Mr. MAILLIARD. Thank you, Mr. Chairman, it has been my pleasure.

Mr. ROGERS. Our next witness is the Honorable William D. Ford of Michigan. Welcome, sir. Come forward and have a seat.

STATEMENT OF HON. WILLIAM D. FORD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. FORD. Mr. Chairman and distinguished members of this subcommittee, I would first like to express my appreciation for being able

to present my views to you today concerning the U.S. Public Health Service hospitals and clinics. Thank you for this opportunity.

I would like to use this opportunity to express my very deep concern over the recent reports that the administration is considering closing or removing from Federal control the eight remaining general hospitals and the 30 outpatient clinics operated by the Public Health Service.

Quite frankly, in light of the legal opinion rendered by Elmer B. Staats, Comptroller General of the United States, I am amazed that the administration continues to presume that it possesses the legal authority necessary to take this action. According to the Comptroller General, the closing of Public Health Service hospitals is beyond the discretionary authority of HEW. I would like to emphasize that the Comptroller General states specifically in his opinion:

> Today, under the Public Health Service Act of 1944, 42 USC 201 et seq., the statutory basis for the continued maintenance of the PHS hospital system, in our opinion, remains. We agree with the view expressed in the HEW memorandum that the Congress in enacting the 1944 act assumed that the then existing PHS facilities would continue to be utilized, and thus maintained.

The Comptroller General also points out that the authority of HEW to refer beneficiaries to public or private hospitals, at the expense of the PHS, is limited to meeting overflow conditions and cases where beneficiaries may be remote from any service facilities.

Next, I would like to say that I find it somewhat difficult to reconcile the administration's consideration of closing down these Government medical facilities with the President's recent statements concerning this Nation's commitment to health. In his State of the Union message, President Nixon stated:

> America has long been the wealthiest nation in the world. Now is the time we become the healthiest nation in the world.

Closing down the Nation's first and most efficient form of Government-supported medical care can hardly be considered a proper step towards becoming "the healthiest Nation in the world."

I would also like to point out that recently Congress, with the President's concurrence, expressed its intent to expand the role of the PHS. I refer specifically to the Emergency Health Personnel Act of 1970 which Congress passed and the President, on December 31, 1970, signed into law. This act expands the role of the PHS by authorizing the use of PHS personnel and facilities to meet health needs in urban and rural poverty areas and other areas suffering from critical shortages of health care and personnel. It would seem to me that, if anything, the administration would now be considering ways to expand, rather than to cut back, the facilities and the services of the PHS.

And now that we have established that HEW apparently lacks the legal authority to close these facilities, that any move in this direction would be contrary to the President's own publicly stated policies and goals, and that any such move would be clearly against the intent of Congress, I would like to make some reference to the people who would actually be affected by the closing of these facilities. The PHS hospitals and clinics provide comprehensive health services for more than 500,000 people annually. Medical care is provided for American Seamen, Coast Guardsmen, and PHS personnel as well as Department

of Defense personnel and their dependents. Many Federal employees are treated by these facilities. Many retirees receive treatment at the clinics. Before any action is even considered, I think we must ascertain the costs of alternate ways of providing these people with equivalent comprehensive health services. I personally do not believe that there is any alternative which is more efficient than the system which presently exists.

Mr. Chairman, I would now like to make some observations with respect to the PHS outpatient clinic in Detroit, Mich., which treats eligible patients residing in my Congressional District. This clinic averages more than 110 cases daily, nearly 28,000 annually. In addition to American Seamen, DOD personnel, and PHS personnel, employees of the U.S. Bureau of Prisons, the Immigration and Naturalization Service, and other Government agencies are treated here. Many retirees and their dependents receive their health care at these facilities. During a recent 6-month period, over 2,600 Federal employees, including a number of postal workers who received on-the-job injuries, were treated at the Detroit clinic. I would certainly be interested in knowing how these people will receive their health care and to what additional inconveniences they will be subjected if this clinic is closed. And I would also be interested in seeing some accurate estimate of the new costs to the Federal Government in carrying out its obligations to these people in the absence of a local PHS facility.

Another service which is provided by the Detroit clinic—and, I am sure, by most of the other clinics as well—is conducting the executive-type physical examinations which the Federal Government requires of many of its upper-echelon employees. These physicals are presently conducted by the PHS clinic in Detroit at a cost to the Federal agency involved of $10 to $12. In contrast, I am told by practicing physicians that private practitioners would charge from $50 to $100 to perform these same physicals.

As an example of the type of service rendered by the Detroit clinic, I would like to refer to the physical examination which this clinic performs for FBI agents. At a cost of $10, the Detroit clinic renders a complete medical examination which includes an electrocardiogram and interpretation, and audiogram, a chest X-ray, a blood and urine test, serology, an exercise and cardiac evaluation, and testing for color vision. It would be very interesting to know where else the Government could obtain this type of physical examination at such a reasonable cost. It makes no sense whatsoever to close down a Government facility in an economy move if we are going to have to turn right around and begin subsidizing private facilities at a greater expense.

At this point, I would like to discuss briefly the economics of the closing of the PHS hospital in Detroit. We are all well aware that the reason which the administration consistently relies upon to justify cutbacks in the area of health, education, and welfare is economy. But after studying the situation in Detroit, I am not quite convinced that we need any more of this type of economy.

Until 1969, the Detroit facility was operated as a full PHS hospital. On July 1, 1969, however, in an economy move, the Department of HEW closed the hospital and established in its place the outpatient clinic which presently exists. According to HEW, the total cost to the Federal Government was $2,215,939 in fiscal year 1969, the final

year of operation for the hospital. The total Federal cost for the operation of the outpatient clinic for fiscal year 1970 was estimated at $2,166,633. According to my calculations, these figures would indicate an annual savings of only $49,306 to begin with. But I am not quite sure that the Federal Government even realized this savings on this operation. Although I do not have all the necessary figures at my disposal, I do have the actual costs of operating the clinic for fiscal year 1970. And when these actual costs are contrasted with the projected costs, it becomes apparent that HEW's projection was more than 40 percent too low. The projected cost was $495,500; the actual cost was $841,439. According to these figures, even if we assume that all other estimates were projected accurately, the closing of the PHS hospital in Detroit resulted in a first year increase in Federal expenditures of $296,633.

During this same year, there were 495 days of emergency care in local Detroit hospitals—paid for by the Federal Government—and 80 patients were transferred from the Detroit area to PHS hospitals in Staten Island, N.Y., or Baltimore, Md.—again at the Federal Government's expense. During the first 6 months of the current fiscal year, the PHS clinic in Detroit authorized 1,334 inpatient days in private hospitals in Michigan, Ohio, and West Virginia. One again, the full charges in these hospitals were paid by the Federal Government.

In light of these events, I am now very curious to know whether the operation as it now exists in Detroit has actually turned out to cost the Federal Government more than it did when the PHS facility was operated as a hospital.

I think this is one area into which your subcommittee may definitely wish to inquire. Since the Government must pay for either transportation or private hospital and clinical costs, it appears to me that the closing of these facilities may actually cost the taxpayers more in the long run, rather than less—and cause the beneficiaries a great deal of inconvenience as well.

Mr. Chairman, in closing I would like to stress once again that Congress, not HEW, should decide the future of the remaining PHS facilities; and Congress can best decide this only after making a full and objective investigation of the present system as you are doing here. I am fully confident that all of us would welcome true economy, but I am not quite convinced that closing the PHS facilities is the best way to go about achieving this. Hasty decisions which result simply in a bureaucratic shuffling of papers, a great deal of inconvenience to the people affected by the program, and a false savings for one program accompanied simultaneously by increased expenditures for another, is certainly not true economy—it is, in fact, blatantly false economy.

Personally, I would like to urge that now is the time that every effort should be made to build up, rather than cut back the Public Health Service hospitals and clinics. These institutions, in my opinion, should be modernized and improved rather than closed. They must play a greater role rather than a reduced role in this Nation's upward struggle to improve its overall health. Closing the remaining PHS hospitals and clinics at this point would not only be unfortunate, it would be totally senseless.

Mr. ROGERS. Mr. Ford, thank you for your fine statement.

Mr. FORD. Thank you, Mr. Chairman.

Mr. ROGERS. Congressman Lester L. Wolff of New York is our next witness.

STATEMENT OF HON. LESTER L. WOLFF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. WOLFF. I am delighted to have this opportunity to express my strong support for House Concurrent Resolution 98 and the 13 other resolutions which express the sense of Congress that the Public Health Service hospitals and clinics should remain open, and should be modernized and expanded. I am a sponsor of House Concurrent Resolution 153.

When the executive branch indicated that it intended to close the eight remaining Public Health Service hospitals and 30 outpatient clinics, I shared the concern expressed by many of my colleagues that this step would result in a reduction of health services to our merchant seamen, coast guardsmen, military personnel, and their families. Public Health Service facilities provide medical services to more than one-half million people annually who could not obtain these services in expensive private hospitals or in overcrowded VA hospitals. If the PHS hospitals and clinics were closed, these people would have nowhere else to go. This is a matter of particular concern to me, since three of the facilities in question are in my own State of New York.

I was therefore pleased, and relieved, when the Comptroller General rendered a legal opinion last month, indicating that the Department of Health, Education, and Welfare does not have the authority to close the Nation's public health service hospitals. While Mr. Staats' decision is binding on the executive branch, I still feel that it would be useful to have an expression of the sense of the Congress on this issue. I would therefore hope that this resolution will be reported out by the subcommittee and committee and receive favorable action by the House.

Mr. ROGERS. Thank you, Mr. Wolff, for your concise statement. The committee appreciates your thought on this matter.

Mr. WOLFF. Thank you, Mr. Chairman, it has been a pleasure to be here.

Mr. ROGERS. Our next witness is from the State of Texas; the Honorable Abraham Kazen, Jr. Welcome, sir. Please proceed.

STATEMENT OF HON. ABRAHAM KAZEN, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. KAZEN. Mr. Chairman, I am more than pleased to offer testimony on the importance of our Government maintaining the Public Health Service hospitals and clinics. I am compelled to present my views because of the importance of the Galveston Hospital to south Texas.

As has been pointed out, these Public Health Service hosiptals were established in the earliest years of our Nation when, in 1798, the Congress approved the installations to serve merchant seamen. But through the years, to the surprise of no one, these hospitals have become essential health services to Government employees, military

personnel, and civilians. In time of acute need or emergencies, the Galveston Hospital has made important contributions to my district and the whole south Texas region.

It has been the concern of this Congress, as well as all those that preceded it, that our citizens obtain proper medical care. Like many of our colleagues, I have supported many bills and appropriations devoted to health. Certainly the illness or injury or pain for any citizen deserves the concern of every person. I wish that I felt that we had reached the point, in our health care planning, that we could feel comfortable about what we had done. I do not believe this happy time has been reached, and I certainly am convinced that we do not attain that goal by closing hospitals.

I urge that this distinguished committee voice the certainty of the House, the Congress, and the people that the Public Health Service hospitals shall continue to function in the genuine spirit of public service for health.

Mr. ROGERS. Thank you, Mr. Kazen, for your thoughtful statement.

Mr. KAZEN. Thank you, Mr. Chairman and members of the committee.

Mr. ROGERS. The Honorable Joshua Eilberg of Pennsylvania is our next witness. Welcome, sir. Please proceed as you see fit.

STATEMENT OF HON. JOSHUA EILBERG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. EILBERG. Mr. Chairman, distinguished members of this committee.

I want to thank you for this opportunity to testify in support of House Concurrent Resolution 150, of which I am a sponsor, and related legislation. This legislation clearly affirms that it is the sense of Congress that Public Health Service hospitals and clinics not only remain open, but be provided additional funding in order that their services be modernized and expanded.

My district, the Fourth of Pennsylvania, lies wholly within the city of Philadelphia. There are no Public Health Service hospitals within Pennsylvania, but my State is home to two Public Health Service clinics, one in Pittsburgh and one in Philadelphia. These two clinics are among the 30 scheduled for closing under the administration's proposal.

Because of personal knowledge and experience with the activities of the Public Health Service clinic in Philadelphia, I feel very strongly that the facility should remain open. I am sure our colleagues from other States and districts have equally strong views about the hospitals and clinics in their States and districts.

The Philadelphia clinic provides medical care for American seamen in the largest fresh water port in the world. The Philadelphia port ranks first in the United States in annual imports handled and the port, which in 1969 handled 57,536,894 short tons of international cargo, is the third busiest seaport in the world. The care the clinic provides American seamen is inclusive and far more complete than that which they could or would receive elsewhere.

The Philadelphia clinic also provides complete care for on-job medical problems for approximately 90,000 civil service employees.

This care includes laboratory, physical therapy, X-ray, and consultant services.

The Philadelphia clinic serves the general public in the Greater Philadelphia metropolitan area by providing expert consulting services on difficult medical problems. The clinic also provides medical information about foreign travel and immunization for such travel. Its many other services include providing care for Vista, Peace Corps, and USO personnel. It also provides quarantine service when necessary.

Clearly, the Public Health Service clinic in Philadelphia provides care and services which would be difficult and expensive to duplicate. Importantly, this care and these services are essential.

I have been assured by physicians that the cost of providing alternate services or care would be astronomical. Since the closures of both hospitals and clinics have been proposed by this administration in large part as an economy move, this is a fair and important test.

My suspicion is that the Federal Government, or at least its agencies in this case, the Public Health Service and the Department of Health, Education, and Welfare, are trying to effect a budgetary savings without any real consideration for the impact of such a move. Obviously these services are going to have to be provided by some other Government agency, at some other level of Government or by the private sector.

It has been suggested that Veterans' hospitals will be able to provide the services that Public Health Service hospitals and clinics now provide. This is clearly not the case. Nationally, the Veterans' Administration budget for medical care shows a slight increase for fiscal 1972 of some $125 million. I have been informed that this slight dollar increase will not be adequate to meet inflationary pressures on that medical care delivery system and that the VA, in order to make that part of its budget work, plans to reduce the average daily patient census from 84,500 to 79,000. This is tantamount, to closing 11 500-bed hospitals. In Philadelphia, the Veterans' Administration Hospital operates at full capacity, has been forced to lease beds at the Naval hospital to fulfill its obligations, and hardly has the budget or personnel to duplicate the services of the Public Health Service clinic.

If HEW or the Public Health Service believes that State or city agencies are financially or physically capable of duplicating these hospital or clinic services, they are sadly misinformed. Philadelphia's and Pennsylvania's own public health services are now so overburdened, with both city and State enduring continuing fiscal crises, that it is inconceivable that either could muster the resources to duplicate the PHS clinic's services.

Finally, that leaves the private sector. I submit that this Congress is now considering a national health plan, largely because the private sector can no longer deliver health services at reasonable cost to everyone.

We come then to a fundamental question. It confounds me to understand how this administration can propose the closing of 38 operating medical facilities in this country at the very time in our history when it has become apparent to all of us, including the President, that there is a major crisis in the delivery of health care and services. On that basis alone, the proposal defies credibility.

Last week, I was encouraged to learn that the Comptroller General had advised the distinguished chairman of the Committee on Merchant Marine and Fisheries that Secretary Richardson did not have the statutory authority to close the eight hospitals and 30 clinics. In fact, the Comptroller General further advised that the Secretary was obligated by law to maintain a Federal hospital system.

On January 25th, I wrote to the Secretary on this matter and in his reply, dated February 25th, he assured me that he would consult fully with, among others, the appropriate committees of Congress.

I think we in the Congress have a clear responsibility and that is the swift and sure passage of the legislation now before your committee. If the Secretary harbors any doubts about the position of Congress on this matter, early passage of this legislation would put them to rest.

Mr. ROGERS. Thank you, Mr. Eilberg, for sharing your views with us this morning.

Mr. EILBERG. Thank you, Mr. Chairman, for affording me the opportunity to present my views.

Mr. ROGERS. Our colleague from the State of Alaska, the Honorable Nick Begich, is our next witness. Please be seated, sir.

STATEMENT OF HON. NICK BEGICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Mr. BEGICH. Mr. Chairman. I welcome the opportunity to tell to this subcommittee important and revealing information regarding the quality and kind of health services that the U.S. Public Health Service provides in Alaska.

There are more than 50,000 Indians, Eskimos, and Aleuts served by eight Public Health Service hospitals. These Americans receive almost all their medical care from these hospitals. While the Federal Government funds these centers, the care that they provide is hardly adequate by today's standards. Many health services are provided just to children, while the adult population is treated on an emergency only basis. The physicians who provide medical service are greatly overburdened and considering the circumstances and conditions involved, they do a most commendable job. But the problems still exist.

The physicians visit the villagers in their area at least once a year. The physicians hold clinics whenever and wherever circumstances permit. Adequate staffing as well as specialists in critical areas are a rarity and frequently seriously ill patients fail to receive minimum health care. Many consultants are used from the private medical community in Anchorage and other Alaska cities on a donated basis.

One of the major obstacles to a more satisfactory Public Health Service is the lack of physicians. Conservative estimates indicate that there is a need for a minimum of 25 more physicians in Alaska than there are now. At this time there is no immediate plan to secure these services.

Another great problem faced by the Public Health Service is the kind of dental care in the Bush. Manpower is concentrated in the metropolitan areas at the expense of the Bush area and subsequently the services are inferior to those in the city. Recent cuts in the budget have curtailed rural services in a much larger percentage than in other areas of the State and country.

Presently there is an urgent and immediate need not only for keeping Public Health Service hospital and outpatient clinics open, but a more pressing need to make more funds available so necessary operations such as upgrading, modernization, and expansion of all programs and functions that raises the quality of services, can be continued.

The people who suffer most from these inequities are the Alaska Natives. All Americans look forward to the day when quality health care is in the reach of all people. Several Native land claims bills befor the Congress call for an eventual phasing out of the Public Health Services in favor of a State supported health care program. Right now this is not feasible in Alaska. It will take several years before Alaska can assume the obligations and provide maximum health service. Until that time comes the Public Health Service must expand and provide more and better quality medical care to all our citizens.

It seems inconceivable to me that in the United States, given the great medical needs of today, we should be debating whether or not we should close health services. We should have passed this stage many years ago. The question of course should be how can we get better services to more people. The narrow outlook of the budget cutters is irresponsible in thought and inconceivable in action. The obvious scarcity of adequate health facilities should demand expansion rather than reductions and to do otherwise is intolerable.

I strongly urge you, Mr. Chairman, to exercise your power to see that these resolutions are reported favorably out of committee and that they reach the House floor for swift action.

Mr. ROGERS. Thank you, Mr. Begich, for your revealing statement.

Mr. BEGICH. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is a member of our own committee, who has been a leader in this drive to prevent the closing of these hospitals. He has, I think, the largest hospital in his own district and he is very much aware of the facts and what would happen if it were closed.

It is a pleasure for us to welcome our distinguished colleague from New York, the Honorable John M. Murphy. Congressman Murphy, the committee welcomes you and we would be pleased to receive your testimony.

STATEMENT OF HON. JOHN M. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK; ACCOMPANIED BY HOLT MEYER, DIRECTOR, OFFICE OF STATEN ISLAND DEVELOPMENT, OFFICE OF THE MAYOR OF NEW YORK CITY

Mr. MURPHY. I thank you, Mr. Chairman. I certainly welcome the opportunity to appear before this subcommittee today.

At the outset I would like to say I have served in five Congresses with the chairman of this subcommittee, and I know of no man more knowledgeable, more capable, and more active in the field of public health. We are certainly proud and privileged to have you as the congressional leader in this fight to retain a public health service system, as well as a hospital system.

I would ask the chairman and the committee if the Borough Development Director of Staten Island—who is here and is due to testify—could join me at the witness table? He is a constituent of mine, even

though he represents another party, and of course, this is probably one of the few instances where we have a community of agreement, and I ask that he join us at this time. He is Mr. Holt Meyer, Richmond County Development Director.

Mr. ROGER. Mr. Meyer, the committee welcomes you and we are very much pleased to have you present testimony this morning.

Mr. MURPHY. Mr. Chairman, in the back of the room on several tables are 40,000 petitions that were initiated and sent to me by every school, every community group, and by thousands of individuals, not asking, but begging the Congress to assert itself in retaining the Public Health Service Hospital at Clifton, Staten Island. We all know that is the largest Public Health Service hospital in the United States. It has a bed capacity of about 650. We know that only about 430 of those beds are being used because the hospital is only staffed to serve 430 beds. It very, very easily could be used to its full bed capacity.

Those petitions represent the voices of 315,000 people in this one county, a county that has no municipal hospital and that relies upon this PHS hospital for so much medical support, particularly a renal clinic which is the only opportunity for citizens that need dialysis to receive that type of care. It also has cardiology clinics and other clinics that provide special help to this community.

I am sure we all know the problems in the great metropolises that don't have the ability to build hospitals and to staff them properly for the citizens in the area.

Those 40,000 petitions are an urgent prayer by those citizens that this committee will do something to retain the Public Health Service hospital system, particularly that hospital in Clifton on Staten Island.

Of course, we had a site visit by the Public Health Service, or really by a team from the Department of Health, Education, and Welfare. They are aware of this community support. We certainly hope that we don't permit the frivolous action of a budget director who at the last minute, in a line item, is attempting to destroy not only a Public Health Hospital system, but also could destroy the Public Health Service that we need so vitally in this country.

Late last year, rumors began to circulate about the future of the Public Health Service. It was the chairman of this subcommittee that brought it to the attention of the American people, that the eight Public Health Service hospitals and 30 clinics would close almost immediately. The origin of these rumors were in the Department of Health, Education, and Welfare (HEW). A decision was being formulated—without the advice or consent of the Congress—to proceed to closing of the Public Health Service system. This decision was being made in direct response to an edict by the Office of Management and Budget (OMB), to close the hospitals, and to seek coverage for beneficiaries on a contract basis.

This decision was made in secret, in direct disregard for the Congress, and in heartless ignorance of the impact of this decision on the hundreds of thousands of Americans dependent on the Public Health Service.

I commend the distinguished chairman and the gentlemen of this subcommittee for bringing the full glare of congressional and public awareness to bear on the plans of the bureaucrats who are toying with the future of the Public Health Service. We now have full public dis-

cussion of the Public Health Service, and any decision that ensues will be based on the best information available. I also commend Chairman Edward Garmatz of the Committee on Merchant Marine and Fisheries for his early and forthright exposure of HEW and OMB plans for clandestine elimination of the Public Health Service system.

The largest Public Health Service Hospital is located, as I said previously, on Staten Island in my district, and serves the entire New York metropolitan area and beyond.

The hospital began as a 34-bed facility in 1831, and has been treating American seamen and other beneficiaries ever since. The Federal Government formally purchased the facility in 1903, and has had direct responsibility for its operation since that time.

This Staten Island hospital has responsibility for Public Health Service medical care activities within the States of New York, New Jersey, part of Connecticut, part of Pennsylvania, Ohio, Michigan, Illinois, the Virgin Islands, and Puerto Rico. It also operates as a central medical center with direct responsibility for nine satellite outpatient clinics located in Buffalo, Charlotte Amalie, Chicago, Cincinnati, Cleveland, Detroit, New York, Philadelphia, and San Juan.

Additional responsibilities include supervision of contract physicians in Albany, Cape May, Oswego, and Point Pleasant; provisions of consultant service and relief to the Merchant Marine Academy at Kings Point; operation of a central dental laboratory servicing Public Health Service hospitals, 10 outpatient clinics, and 11 Coast Guard bases; regional recruitment and processing of commissioned personnel, maintenance of isolation facilities for quarantinable diseases for the quarantine division; medical evaluations for the U.S. Immigration and Naturalization Service; hospitalization of complex medical care cases for the Bureau of Prisons; training of paramedical personnel for the Federal Health Programs Service, Division of Indian Health, and for the community, including laboratory technologists, X-ray technicians, nurse anesthetists, and practical nurses; provision of immunization service for foreign travelers, including yellow fever, smallpox, plague, and cholera vaccinations; medical treatment and evaluation for Department of Labor, Bureau of Employees Compensation referrals; operation of the east coast leprosy center; operation of the Pharmacist Mate School for ships' pursers; and medical evaluations for Cuban refugees seeking citizenship.

It should be obvious from the foregoing that the Public Health hospital on Staten Island is a principal medical facility on the east coast, serving a wide range of public health functions. Any intelligent consideration of change in the operation of this system must be the product of careful and detailed study by the Department of Health, Education, and Welfare, and the appropriate committees of the Congress. It must not be the result of hasty and arbitrary decision by dollar-conscious accountants in the Office of Management and Budget. And when some of those accountants and executives from the Department of Health, Education, and Welfare appeared before the Subcommittee on Appropriations of the House on this very matter, the chairman of that committee said to me, it appeared to him that their decision to close the hospitals and their subsequent recommendations were made in the taxicab on the way to the hearing that day.

When Dr. Egeberg testified late last week he described three principal alternatives currently under study in HEW. They include maintenance of the present system with expansion into the community, and two variations of a scheme for conversion to local use.

However, judging from the history of OMB and HEW handling of the question of the future of the Public Health Service, it is clear to me that the first alternative is not seriously under consideration. Rather, HEW appears tightly bound to the OEO edict to get out of the public health business. This was not a new attack by OMB; 5 years ago, this same attack took place and at that time several hospitals were closed, but the system did continue operating. This was abundantly reflected in the President's budget, which included no funds for continuation of the Public Health Service.

It is unfortunate that serious consideration of the first alternative—maintenance and expansion of the existing system—is not really taking place. Yet it is this alternative that offers the best course for the future, and it is the course which I heartily recommend to this committee. I support adoption of the many resolutions expressing the sense of Congress that the Public Health Service be maintained as a vital source of primary health care for beneficiaries entitled to care under the law—the law as enacted by Congress, and not the law as interpreted by the bureaucrats.

In this connection, I note that two legal opinions rendered by the Comptroller General of the United States flatly affirm the illegality of HEW administratively terminating the Public Health Service. This service was created by the Congress, and its future should be determined by the Congress. I understand that HEW will submit a legal opinion to the contrary, and I noted with some dismay the assertion by the Comptroller of the Health Service and Mental Health Administration, before this subcommittee, that the ruling by the Comptroller General of the United States merely constitutes "one man's opinion." I hope we shall see about that particular quote.

The Public Health Service is a first-class source of medical care for its primary beneficiaries. It must continue to treat those beneficiaries entitled under the law, and the facilities for the care should be maintained in an up-to-date condition.

The system should also be expanded to make full use of the facilities in the community-at-large (on this we are all in agreement). To the extent that PHS beds are available, they should be used for emergency care for any person requiring care not available elsewhere. They should also be used on a reimbursable basis for care for patients on an elective basis, particularly when the beds would otherwise be idle. In this regard, both medicare and medicaid patients should be covered for treatment in a Public Health Service hospital when other sources of care are not available. Acceptance of patients on a reimbursable basis would be the smoothest and least costly method whereby PHS could extend itself into the community-at-large. Incidentally, this idea is not new—it was receiving active consideration within HEW and elsewhere when the first dark rumors of closing began to seep out.

Further, the hospitals and clinics can and must assume a greater role in the treatment of narcotics addiction. Clearly, it would be absurd to back out of the primary health care business when there is a

crying national need for effective treatment centers for narcotics addicts. The Federal Government is currently expanding its funding and involvement in treatment centers; how absurd to close one ready-to-use system of facilities only to provide greater funding elsewhere in the bureaucratic maze for new facilities.

In this connection, I plan to introduce two bills—one for the Federal commitment of certain new classes of addicts and drug-dependent persons—and, the second to commit service veterans who return to civilian life as drug addicts to hospitals for treatment. The PHS is eminently suited and capable of treating these addicts. If we proceed with dismantling the PHS, then we will only have to go elsewhere—at greater expense—to treat these addicts. They are not going to disappear, and society will have to treat them one way or another.

Since the first rumblings of closing began, the thousands of dedicated personnel in PHS have lived with doubt and uncertainty as to the future of their jobs. This doubt has inflicted harm throughout the system, and has affected recruitment of new interns, doctors, nurses, and other professional, paraprofessional, and nonprofessional personnel. This doubt and uncertainty can potentially destroy the high-spirited dedication of these men and women, and it could deal a fatal blow to PHS by attrition. I remind you that most of these people work for PHS at salaries far below those available in private medicine. Doubt and uncertainty will ultimately drive them away.

When Dr. Egeberg appeared, he frankly admitted that any alternative under consideration would involve a vast increase in the funding of PHS or service to its primary beneficiaries under contract arrangements. This is a far cry from the early OMB interest in reducing costs, and thoroughly negates any argument emanating from that corner of the Government.

Meeting our legal and moral responsibility to PHS primary beneficiaries, and intelligent expansion into a greater community role, will certainly cost money. However, the greatest savings—in dollars and lives—will ultimately be achieved by improving and expanding our existing system, rather than inventing new bureaucratic schemes for conversion and contract care.

Mr. Chairman, and my colleagues on the committee, I urge prompt consideration in passage of H. Con. Res. 98, and similar measures, and early consideration of the best future role of the Public Health Service.

Thank you.

Mr. Rogers. Thank you very much, Congressman Murphy, for a very thorough statement and very helpful statement in sizing up the situation in your particular area.

Mr. Nelsen.

Mr. Nelsen. Mr. Chairman, I note in the statement of my colleague, you refer to the origins of these rumors. Now, frankly, when this hearing started apparently a good deal of background work had been done which I have never seen, and there is much information that I would like to have that I don't have. I made it my business this morning to do a little checking on my own, and there is no intention, in my judgment, on the part of anybody to close a large number of these hospitals, that others seem to feel are about to be doomed.

In the hearing, Dr. Egeberg mentioned where the hospitals were doing a job they would be continued. But the purpose of the HEW is the same purpose that you cite here, and the same recommendations that you make, that the facility be expanded to accommodate a community, the total needs of a community. I think that we should not overlook the fact that there may be some recommendations involved that will improve the service, and expand it, making the hospitals totally usable in the various communities.

I am sure you would agree, because your own testimony indicates it, that the facilities should be used to the maximum, not only for the original intent of the act, but also for meeting community needs.

I hope our committee will examine the report when we get it. We don't have it yet. I don't know what hospitals would be closed, or proposed to be closed. I have no notion as to which would be left open, but I do think that rather than leave an impression, we had better know what we are talking about before we go too far on just rumors. I am sure you will agree our committee will do a job, and I am sure we will have your cooperation in whatever we do.

Mr. MURPHY. In response, Mr. Nelsen, I point out that 5 years ago the President's Commission on Hospitals Report came out, and the recommendation of that hospitals commission—and we had the same type of rumor going on at that time, that Public Health Service hospitals would be closed, and we had a great fight here in the Congress to retain them, a fight which subsequently was won at the expense of the closing of some facilities, but the recommendation, the strong recommendation from that commission, was to improve the present hospitals.

Now, no improvement of the present system has been made in the past 5 years. We know it has not been made, even though the Interstate and Foreign Commerce Committee authorized 12 million for the improvement of this one hospital at Clifton, Staten Island.

But the general manager of the United States in the OMB never put the appropriation in the budget. So, for 5 years—and this is no rumor, this is hard fact—the OMB has failed to do anything about the commitment of the Congress to improving this system.

Now we hear rumors again. But these are rumors based on strong facts. For example, when the OMB comes out with $69 million merely for contract medicine to replace this entire hospital system, then we know that there is more than mere rumor involved. We know that the basic attack is against the Public Health Service hospital system, because when you get rid of the hospital system, you get rid of the teaching and the ability to attract doctors into Public Health Service. Then the next thing would be a total contracting of all Public Health Service functions to private medicine and the witnesses before this very committee testified that $125 to $150 million would be necessary to perform the $69 million mission that the Public Health Service hospital system is performing in the United States today.

Mr. NELSEN. Now, you mention the OMB, the budget. We make the appropriations in the Congress; there is nothing that would have stopped the Congress from appropriating money to do the job that obviously Congress wants to do, but seemingly the practice around here is to blame somebody else for our mistakes sometimes. This often happens. So we institute programs, then we don't fund them. So, we

need to share a little of the blame here, too, and certainly we don't want to close hospitals if we need them.

I want to compliment you on your recommendation on page 3, where you say that the facilities should be sort of a community-at-large approach, which I think is very necessary, and probably one of the gravest mistakes that has been made in the past is that these hospitals, the doors haven't been opened to an adequate number of people to make it a fiscally sound economic operation.

I think you will find on checking, that this will be a part of the recommendation from downtown where these hospitals are operating, they be made available to a community-at-large recommendation as you have indicated in your testimony.

I thank you gentlemen.

Mr. MURPHY. I thank the gentleman.

In response to the Congress meeting its responsibility in appropriating funds, the chairmen of the appropriate subcommittees have indicated to me, and I am sure to other Members of the Congress, that they would not entertain putting additional appropriations in the budget. They said if there is a funding to be made, unless the Bureau of the Budget or the OMB has it as a line item in the budget, they cannot under the deficits that this country has had in recent years, simply add such things into the appropriation. I think the history of the Congress, especially the last two Congresses has been to cut the recommendations of the Budget Bureau rather than to substitute line items. That is what we face here, the destruction of a program simply by eliminating it from the budget.

Mr. NELSEN. No more questions.

Thank you, sir.

Mr. ROGERS. I might point out, too, that the Congress has actually appropriated money for planning and improvement, and it has not been signed by the Executive.

Mr. Symington, any questions?

Mr. SYMINGTON. No, thank you.

Mr. ROGERS. Doctor Carter?

Mr. CARTER. Certainly.

I have listened with interest to the presentation of the distinguished gentleman and find it quite interesting.

I notice, however, your average occupancy rate in the hospital is 66 percent. You have 636 beds and you are utilizing only 420 there.

Mr. MURPHY. Right.

Mr. CARTER. It seems to me this was one of the reasons why the hospitals are being closed, because they are not being fully utilized, one purpose of that.

Mr. MURPHY. Doctor, I asked the same question of Secretary Richardson. His response was the mathematics that you just gave me.

My response to him was you have only staffed this hospital to care for 420 beds; 100 percent of the current staff capacity is being used in that hospital.

Mr. CARTER. What proof do you have of that, that staffing is only up to 420?

Mr. MURPHY. Those are the Public Health Service Hospital figures.

Mr. CARTER. I have their figures here. I just read some of them, but they didn't state about the staffing.

It is my impression they furnish sufficient staff, whatever is required.

Mr. MURPHY. Only for 420 beds.

Mr. CARTER. I was interested further in some other remarks you made about this, the great service it renders to your area and without a doubt it does. But the services are given to merchant seamen, Coast Guard commissioned officers and national oceanic and atmospheric personnel throughout this area. Actually, it is not a community facility as you envisage. It is a specialized facility, is it not?

Mr. MURPHY. Doctor, it is a specialized facility.

Mr. CARTER. For these people, in particular?

Mr. MURPHY. Many others who are government dependents of military personnel in the area, or military personnel overseas who reside in this area, which accounted for something like 300,000 outpatient visits. It is the responsibility of the Federal Government to provide that type of medical care.

Now, in further response to that, this hospital is affiliated with the five major teaching hospitals for doctors in the New York area, and without this hospital system and the ability to affiliate with the five schools, we wouldn't have the competency in the Public Health Service we now have.

Now, the citizens of our community, in effect provide a definite service to the Public Health Service, because every rare type of operation that is necessary in this community, the Public Health Service Hospital takes the patient in, performs the surgery in an amphitheater and trains the Public Health Service doctor.

I was instrumental in having the Veterans' Administration with their 4,000-bed backlog provide additional beds in this hospital to the Veterans' Administration who can't handle their casework and their caseload. That is the type of community involvement that this hospital has. I say it should be made part and parcel of the mission of the Public Health Service.

Mr. CARTER. Well, really it services a specialized group. I really think that hospitals should be included in the community, perhaps, but other than that, of course, our laws would have to be changed in order that people in the community could be given attention there, the rank and file people instead of specialized groups which you mentioned.

Have you ever visited the hospital?

Mr. MURPHY. I visit that hospital on an average of once a month. My office is in constant communication with our hospital on a daily basis.

Mr. CARTER. Yes.

Have you ever visited a little part of the hospital called Snug Harbor?

Mr. MURPHY. Snug Harbor is located about 4 miles from this hospital. I have also visited that many times.

Mr. CARTER. What is Snug Harbor?

Mr. MURPHY. Snug Harbor is a private foundation that provides a home for homeless seamen.

Mr. CARTER. And in almost every Public Health Service Hospital that we have there are certain areas that are committed to older seamen who come there for different periods of time during the year, and this is what I had reference to, and not to the Snug Harbor which you mentioned.

Now, I believe you stated that you envisage in the future that this hospital should give primary care to the people of the community around this—in Staten Island, is that right? Is that not true?

Mr. MURPHY. Yes.

Mr. CARTER. All of them, not just specialized groups.

Mr. MURPHY. Medicare and medicaid patients.

Mr. CARTER. Medicare and medicaid?

Mr. MURPHY. Yes.

Mr. CARTER. All right, sir.

Of course, that is contrary to the present law?

Mr. MURPHY. The law states that on an outpatient basis medicaid patients can and are being treated by that hospital under a strict interpretation of the law by the Under Secretary, not the Secretary, in response to the very question that you asked. I asked the Under Secretary and I also had the Comptroller General answering that legal question. I think they can provide inpatient care as well as outpatient care.

Mr. CARTER. This is a difference of opinion. This is something that has never been recognized by the Public Health Service. I know how difficult it is for patients to get in. They have to prove their status before this is done.

Now, you spoke of it being sort of a community hospital for Staten Island. Again, I think it is a good idea that it be that way, but certainly we would have to have changes in the personnel and in the hospital and in, perhaps, the ownership of the hospital if we did this.

Then you stated that all addicts might be treated here, too. If we did all the things that you envisage, we would probably end up with a 2,000-bed hospital.

Mr. MURPHY. Doctor, I did not say all addicts. I said certain classes of addicts and veterans of the military service who are drug dependent.

Mr. CARTER. Well, I remember you mentioning that, but you mentioned addicts also, and I toook that as addicts. Maybe I am wrong.

Mr. MURPHY. Well, it is clear in my statement.

Mr. CARTER. I believe that the Secretary would like to include in this to make community facility of it, and not just a specialized facility for certain groups, but have perhaps a health-maintenance organization there. This is the idea that was developed before this committee. There is no intention that I know of to give them the Public Health Service.

Just last year, we passed a bill which would permit commissioned officers of the Public Health Service to go into ghetto areas and rural areas, as you know. I feel that many of your fears are unfounded. I am afraid that some of our hospitals have not been utilized as fully as they should have been and have been rather inefficient, and the average days have been pretty high, as it is in yours, 19.4 days, I believe, is an average; something like that.

Mr. MURPHY. The last information given to me was that it was 17 days in that hospital.

Mr. CARTER. I beg your pardon, 19.5, Staten Island Public Health Service Hospital. I have the figures right here.

One other hospital has a longer—one-tenth of a day longer than that, and that is Boston.

Yes, sir.

Thank you, Mr. Chairman.

Mr. MURPHY. Mr. Chairman, I would like to respond to the Doctor. I represented ghetto and slum areas of the city of New York, and I made this statement earlier that here we have what I think is an assault on the Public Health Service medicine by private medicine. Private medicine is trying to get rid of any form of Government medicine.

Now, as far as medical care to people in slums, I am an adviser to the Brookdale Hospital. The Brookdale Hospital is the hospital for the slum patient. Doctors don't go into homes and they don't provide clinical services except under a Government program, where private doctors were permitted to establish a clinic in a ghetto area.

My experience with those clinics, as borne out by the Coney Island Hospital, which encompasses one of the worst slum areas of New York, was that private doctors would form a clinic to provide a type of medical service. This was in the areas of physicals and diagnoses. We found cases where the ghetto patient was getting a physical without taking his tie off and that was the type of medicine that was being processed on a private basis on a Government program in a ghetto area.

Unless in a city we can have some form of Federal medicine, particularly as we are recommending here, I don't think we are going to have the ghetto or the slum area receiving any type of medical care, because on a private basis you will not have the private physician going in to provide medical care in those areas.

Mr. CARTER. Mr. Chairman, if I might respond.

If you need this hospital, certainly on a community basis as you suggest and to provide health for ghetto areas, I am all for it. Let's expand it and do that, but continuing it in its specialized form, it is not accomplishing the purpose you want.

Mr. MURPHY. What we want to do is retain the hospital to perform its present mission with its available extra bed capacity and ability on an outpatient basis to have it performed under medicare and medicaid programs, programs approved by the Congress; that type of medicine for a community which it is perfectly able to perform and as a consequence provide better training to the Public Health Service system.

Mr. CARTER. If we could permit that, then perhaps the hospital could go on, could continue, but we are going to have to do something like that. We can't continue to specialize, certainly, in these separate lines of treating separate patients. But if we did accept medicaid and medicare patients, then the hospital could exist, I think. But those things, I think, must be out.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I have no questions.

Mr. ROGERS. Mr. Schmitz.

Mr. SCHMITZ. I have no questions, but I think I should take this occasion to make a comment.

I would like to comment on the same part of your testimony which has already been referred to, expanding the facilities to make full use of them in the community-at-large, and parenthetically, on the written testimony we are all agreed. I believe when you read your testimony you gave it slightly different from the script. So I guess I should be commenting on your hopes, rather than arguing against the facts you have preserved. I am not agreed on this and, apparently, I differ with some of my colleagues from my party, according to previous comments.

The issue as I have seen it developing in these hearings is somewhat of a mini-issue or a subtheme, I might say, of a big issue that we are going to have with us all year. As the Federal Government expands its role in medicine, we are going to have many of these problems developing, because the argument so far has been as the Government gets in to furnish care to all people, what are we going to do with these people the Federal Government has taken care of prior to its move to expand to cover all people.

Both in these hearings and through the discussions so far on the role of the Federal Government in medicine in general, there has been an assumption that everyone agrees that the Federal Government's role should be expanded. That was the point that I wanted to comment on, and my failure to comment during these hearings every time this implication is made, should not be taken as acquiescence in the assumption that Federal Government's role should be expanded. This subcommittee has expanded the spectrum and given that as an option. I consider that many of the problems we have in medicine today result from the Federal Government's incursion into the field, and more Federal Government into the field is simply going to compound the problems, rather than solve them.

Mr. CARTER. Would the distinguished gentleman yield?

Mr. SCHMITZ. Certainly.

Mr. CARTER. One of the things brought out here, and I regretted to hear this, that a statement of the distinguished gentleman that certain physicians under contract had done physical examinations without taking off a person's tie even, under Government contract. I would hate to—well, this may exist, I certainly hope it doesn't exist throughout the medical profession. The part I know, seldom do we see this. Occasionally so.

Mr. MURPHY. If the gentleman would like to come to the Coney Island Hospital, I am on the board of directors, if you would like to go out and see just what I am speaking of, I would be happy to take the gentleman. That is just one neighborhood. I will be happy to take him to five more neighborhoods and show him the same thing.

Mr. CARTER. If that is the form of medicine whereby Government employs people to examine people and they don't have them take off their ties for the physical, certainly I am opposed to that.

Mr. MURPHY. Certainly, this is not the intent of Congress.

Mr. NELSEN. Mr. Chairman, you make a point that proceeds on the basis that we are going to close those hospitals. I think that is unfair. I do not think it is accurate.

Dr. Egeberg, when he appeared—and I don't think we have pursued our questions with him adequately—and I think we are a little premature perhaps because we don't have his final report. He repeatedly made the statement that he was desirous of making these hospitals community-involved doing exactly what you are suggesting in your testimony. We proceed on the basis they are going to close. We don't proceed on the basis that we want a better hospital.

I think that is what we really want, and I think this is what you will find the subcommittee will seek to gain.

So often I have been aware of the fact that we build a political issue rather than finding an answer. Now, the answer that I want is to be assured that every hospital is doing a good job. I am sure you

want to do the same thing, and I think you will find the subcommittee will try to move in that direction. I am sure Dr. Carter and you and I and the whole committee would agree that the objective is to make better hospitals.

Thank you, Mr. Chairman.

Mr. ROGERS. I might say that I share the concern about the closing of the hospitals. I think what has brought this to a head actually is the fact that the Budget includes no money for the operations of these hospitals after July, so that is a budget decision. Unfortunately, Budget has overruled HEW often. What this committee is trying to do is build a basis where we can change that. I am hopeful we can do it. I believe we can with the information we are hearing.

Now, Mr. Holt Meyer, would you identify yourself for the committee.

STATEMENT OF HOLT MEYER, DIRECTOR, OFFICE OF STATEN ISLAND DEVELOPMENT, OFFICE OF THE MAYOR OF NEW YORK CITY

Mr. MEYER. Yes, I will.

My name is Holt Meyer. I am the director of the Office of Staten Island Development, which is a part of the office of the mayor of the city of New York.

I would like, first, to commend Congressman Murphy on his excellent initiative and leadership, he, together with Mayor Lindsay, and President Connor have been leading the fights in New York City to keep the Staten Island Public Health Service facility open, and indeed to expand the service to the community as a whole.

I deeply appreciate this opportunity to appear before you to present the views of one community whose health care needs will be seriously jeopardized by the closure of a U.S. Public Health Hospital.

We in Staten Island recognize that the PHS hospitals were originally intended to care for a limited clientele. But, the fact remains that these hospitals, of necessity, have adapted to changing national needs by extending their vital health services to all of the citizens of surrounding communities. Today, the responsibilities of the PHS hospitals go beyond their historical mandate and reach thousands of Americans who are now dependent on the care these hospitals provide. To simply abandon these institutions would not only deprive these countless citizens of essential medical care but would eliminate an important national resource for the training of skilled Public Health personnel—all of this at a time when the Nation is suffering from a recognized crisis in our health delivery system.

There is no better example of the role these hospitals have performed in relation to their communities than that of Staten Island and the Public Health Hospital in Clifton. As a representative of the mayor in this community, I have seen at first hand how essential this hospital is to meeting the minimum health requirements of the people of Staten Island. This facility is not only responsible for the PHS medical care activities for the Northeastern United States and Puerto Rico, it also functions as an emergency relief hospital for our residents, a medical research facility available to local needs, and a medical training facility for all of our educational institutions on Staten Island.

According to the 1970 report of the "Health and Hospital Planning Council of Southern New York," as of January 1, 1970, there were only five hospitals in Staten Island providing hospital care facilities, excluding Federal and State installations. These include the three voluntary hospitals (St. Vincent's, Staten Island and Richmond Memorial), and one proprietary private, all of (Doctor's) which have a total bed complement of 881 beds. The city's Seaview Hospital and Home is mainly used for geriatric care, with only eight beds available for general care (medical-surgical service).

The critical factor in measuring present utilization and overcrowding of hospital facilities is the bed occupancy rate for medical-surgical service. For 1969, this occupancy rate was 101.9 percent for the five hospitals, and as high as 111.0 percent for Richmond Memorial and 102.9 percent for St. Vincent's. This compares with the medical-surgical occupancy rate of 87.9 percent of all New York City hospitals. Thus, Staten Island exceeds the average city rate by 14 percent. From all indications, this same high rate of Staten Island hospital utilization has continued through 1970 and into 1971.

In 1964, the hospital council made a study of the general care bed needs of Staten Island. At that time, the council recommended an additional 50 to 70 medical-surgical beds to be added immediately to meet the demands of the current population. Also, the council recommended that an additional 100 medical-surgical beds beyond those needed in 1964 be constructed to accommodate the anticipated population growth by the year 1970.

Today, over 7 years since that report, Staten Island has indeed become the fastest growing borough of New York City and yet, despite this fact, only 63 of the needed 150 to 170 beds will be in existence and that will not be until the end of 1971.

Clearly, Staten Island is at the limit of its hospital capabilities to care for its residents. This situation will aggravate as the population expands. The present rate of growth is 3.5 percent a year, compared to the other boroughs which, except for Queens, are declining or are stabilized in population. The 1970 U.S. Census of Population showed a 33.2 percent growth rate since 1960 for the Island compared to 0.2 percent for the entire city. As more than half of the city's vacant land is in Staten Island, the population growth rate could easily double once large-scale housing construction resumes.

As far as plans for additional capacity, Staten Island General Hospital has received approval from the hospital planning council to relocate and expand its facilities at a new location, but it will be at least 4 years from now before construction would be completed and new facilities available to the public.

Fortunately, the PHS Hospital has been able to meet this growing need for emergency beds. Without such available care, Staten Island would immediately face a health crisis of the most serious proportions. Emergency care would have to be transported over long miles to facilities in other boroughs, New York City and/or New Jersey and many of these are also facing crowded conditions.

In a real sense, the continued services of the PHS Hospital in Staten Island could mean the difference between life and death for many of the citizens in our community faced with emergency health needs.

In addition to such emergency care, the hospital's outstanding research skills and facilities are also available on medical referral in such areas as renal dialysis, cardiopulmonary diagnostic studies, artificial lung, cobalt therapy, and others. The loss of such highly specialized skills and equipment would have a serious impact on the quality of health care for our community.

The PHS Hospital on Staten Island also plays an invaluable role in health manpower training. Several of the medical educational programs of Staten Island Community College, Wagner College, and Richmond College, are dependent on their students using the Clifton buildings. It would be tragic indeed to shut down a facility which is training medical specialists and technicians at a time when there is a critical shortage for such personnel in the city and the Nation. To do so would be a false economy because the cost of providing these facilities and training programs elsewhere would be far greater, if provided elsewhere.

Along with such training, the PHS Hospital provides examinations and pediatric treatment for Headstart and daycare center children which would not otherwise be available to them. Local mothers tell us that the care now offered to their children at the hospital is the most complete they have every received. Aside from medical services provided, it is also well to focus on the economic impact such a closure could have on a community like Staten Island. As the second largest employer in our community, the loss of the PHS Hospital would present serious economic dilemma to over 1,000 families on Staten Island at a time when the Nation's economy has already robbed them of much of what they can afford. Surely, they too must be considered in any decision regarding the future existence of such a hospital.

These are some of the factors that we in a community served by a PHS hospital are faced with if the Government proceeds to close such a facility. For the Federal Government, it may well be a matter of balancing figures on a budget sheet. But for local government, it means balancing the lives of its citizens and their health needs * * * it means struggling to maintain a minimum standard of health care * * * it means losing needed health manpower and training * * * it means economic deprivation of more of our citizens. We ask the Congress to carefully weigh the full impact of such a step. We cannot afford to lessen the quality of health care we provide. We cannot, as a nation, afford to have the PHS hospitals closed.

Thank you very much, Mr. Chairman.

Mr. SYMINGTON (presiding). Thank you, Mr. Meyer.

I wish to say to my distinguished colleagues that I hadn't expected on my first appearance as a member of this committee, to find myself in this precise spot.

But I did also want to say, since I heard the gentleman from New York as I came in referring to the focus of his particular interest, that there is a fort on Staten Island known as Fort Wadsworth, which is named for Gen. James S. Wadsworth, who was my great, great grandfather, and he received a Minié ball from an Alabamian in Virginia and was taken home to New York and to his fond rest and does now look at all of the ships that come through. I would certainly hope that he would not find behind him inadequate services to the seamen, the veterans, and the people that are helped there.

But I have been very interested, not only in your testimony, Mr. Murphy, but Mr. Meyer's. However, before putting any questions of my own, I wonder if Mr. Nelsen would like to ask a few.

Mr. NELSEN. I have no questions, but I say to my colleague, welcome to the Chair. I just whispered in his ear that if he had his guitar and I had my fiddle we could give you a show.

I can well understand the concern of any community that may find a facility threatened that is serving a purpose. I think you would agree with me, and this I gather from your testimony that we should be reaching out to make the facility a better one. I think part of the objective of HEW is missed when we look at something that we may not quite agree with.

But Dr. Egeberg's statement did, in response to my question, indicate that what he wanted was a total involvement of a hospital to serve a community's needs, and this was his primary objective. I think you will find our committee very responsive to your needs, and we will do the best to see that the public is served in the best possible way. It certainly would be my purpose and I think that of Dr. Carter, and our other expert—Dr. Roy, who is also a medical doctor.

Mr. SYMINGTON. Mr. Preyer, would you care to ask some questions?

Mr. PREYER. Mr. Chairman, first, I want to say I am sorry about your grandfather's Minié ball.

Thank you for your testimony, Mr. Meyer, and I am sorry I was a little late. It certainly indicates from these bad occupancy rates that you must have the tightest hospital picture, among the tightest in the country, Staten Island. I certainly hope this committee can help in some way to do something about it.

Thank you very much.

Mr. NELSEN. Would the gentleman yield?

Speaking of his grandfather having a little difficulty with some lead poisoning, recently I was down in North Carolina and I heard about a general leading the Tories, and it was said he was shot from his horse, with seven bullets going through his body, but it was a good thing, it stopped him from further mischief.

Thank you.

Mr. SYMINGTON. They have that effect.

Dr. Carter.

Mr. CARTER. Thank you, sir. I think one of the main problems is the incomplete utilization of the bed facilities in the hospital of Staten Island. I feel that is one of the problems. I feel that the Public Health Service is here to stay with us. We are going to have it.

Furthermore, I feel that the problem will be worked out. Of course, it will necessitate some strong regulations or legislation so that a facility can be built that will be—or present facility can be changed so that it will benefit more people in the area. When you say that 66 percent occupancy rate, that immediately strikes people throughout the country, and the hospital people, of course, see this, that it is inadequately used.

Mr. MEYER. Doctor, I would like to reaffirm what Congressman Murphy stated before, and that is—and I have confirmed this with the local managers of the hospital, that they are indeed only staffed to care for that number of beds. I believe during World War II they served 1,000 beds there and were so staffed. So that I just wish to reaffirm what the Congressman has stated heretofore.

Mr. MURPHY. The reduction of available staff is a device used ostensibly to show that a facility is only operating at 66 percent of its capacity. The fact is, of course, this hospital is operating at 100 percent of its staff capacity. This is just another contrived excuse for trying to close these hospitals.

Mr. CARTER. Well, I wish we were in possession of such concrete information from HEW.

Mr. MURPHY. The hearings before the House Merchant Marine and Fisheries Committee last December will confirm this with the figures. It is a matter of record in the congressional hearings.

Mr. SYMINGTON. Dr. Roy.

Mr. ROY. I have no questions, thank you.

Mr. SYMINGTON. Mr. Kyros, would you like to ask questions?

Mr. KYROS. Thank you.

I am glad to see my colleague, Mr. Murphy, here. I want to commend you on the statement which I read.

I would like to ask you some questions on what I think you have touched on which no one has brought out to date on this hospital service, although they have shown the same kind of concern you have.

I think it is an interesting suggestion that these hospitals and clinics could assume a greater role in the treatment of narcotic addicts. I would like you to spell out more fully the role of returning servicemen we have from Vietnam today or what role they could play in the function of the——

Mr. MURPHY. The military service in particular. The Air Force in an announcement 2 days ago stated that they had an open arms policy on drug usage within the service.

Mr. KYROS. Amnesty?

Mr. MURPHY. Amnesty. Well, I used another term.

There are these drug problems, to my specific knowledge. In my area young servicemen come to me for treatment and I have to send them to methadone centers, for treatment in Phoenix houses, for treatment in other similar facilities. I say, here we have this facility on Staten Island and this massive drug abuse problem, and it is obvious the Public Health Service certainly should be able to address itself to it. If my legislation is passed we could establish a treatment program in an area where there is not even a methadone clinic and this is a high drug use area.

More important, my bills would provide that such a treatment program would be available for our returning servicemen who are drug dependent.

Mr. KYROS. So we could specialize in the treatment of narcotics problems, if the patients are service-connected men coming back from Vietnam and other areas?

Mr. MURPHY. Yes, sir.

Mr. KYROS. Thank you, Mr. Chairman.

Mr. SYMINGTON. Thank you.

I have no questions of Mr. Murphy or Mr. Meyer.

If there are no further questions, we thank you for your kindness in coming today and giving us your testimony.

Mr. MURPHY. Mr. Chairman, I hate to close on a sour note, but the Federal Government just announced the closing of Fort Wadsworth as surplus to its needs.

Mr. SYMINGTON. My family has had a hard time over the years.

I should like now to call my chairman of the Science and Astronautics Committee, the Honorable George Miller of California, to give us his testimony this morning.

STATEMENT OF HON. GEORGE P. MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. MILLER. Thank you very much, Mr. Chairman.

Mr. SYMINGTON. This is another unexpected surprise for me, too, Mr. Chairman.

Mr. MILLER. Thank you very much.

Mr. Chairman, I want to thank you and this distinguished subcommittee for the opportunity to make this statement on behalf of legislation expressing the sense of Congress in opposition to the closing of a number of Public Health Service hospitals and clinics. I am one of the cosponsors of H. Con. Res. 156. I am particularly concerned since one of the hospitals earmarked for closing is located in San Francisco, and while that is across the bay from my district, it is in the same general metropolitan area.

If this and other hospitals are closed, there will be many seamen, active and retired personnel, of the uniform service and their dependents, who will be without adequate health care to which they are entitled.

It has also come to my attention that the General Accounting Office has advised the chairman of the House Merchant Marine and Fisheries Committee that in their opinion they do not think the Department has the authority to close these health facilities.

The suggestion made by the administration that alternative health care will be provided by the Public Health Service under service agreements with the Veterans' Administration and private hospitals in various communities is utterly ridiculous.

We all know there is a shortage of hospital beds, both in public and private institutions. If these public health facilities are not being used to capacity, as indicated by the administration, they could and should be turned over to the Veterans' Administration or some other agency that can continue to provide the care for which the Government has assumed responsibility.

In closing, I want to mention that these public health facilities have served the country well and the excuse for economizing does not justify their closing. I hope the subcommittee will act favorably on this.

Listening to Mr. Murphy brought back some memories of mine that go back to 1919 and 1920. World War I veterans returning from France were treated in Public Health Service hospitals and they were crowded. The ones that I was familiar with were old hospitals, and they had people even in the halls. It wasn't until 1920, after a great cry had been raised, that the Government consolidated the work of the rehabilitation section of the Bureau of Rehabilitation and the Public Health Service medical facilities into the then Veterans' Bureau, the forerunner of the Veterans' Administration.

The early doctors who staffed the Veterans' Bureau were transferred from the Public Health Service.

Now, the Public Health Service, to me, is one of the greatest institutions in our Government. I think they are well-staffed, but I am concerned with the National Institutes of Health. These hospitals have been the place that they could send their doctors to put into effect the great things that they have learned in the National Institutes of Health. To me it is unthinkable that you are going to close them. While I can only speak for my own State of California, there hasn't been a year that the veterans' groups have not come before our delegation pleading for more hospital beds in California for veterans.

Here are well-equipped hospitals that are going to close down. They could be turned over to the Veterans' Administration. Of course, they are going to have a hard time staffing them, but this is part of the population explosion. We haven't enough good medical schools to supply the doctors needed to provide proper medical attention to the people.

I think it is utterly ridiculous to talk about closing down these institutions that could be used by changing the law directly authorizing their staffing by the Veterans' Administration. I can see a dozen ways it can be done.

For 5 years after World War I, I served with the Veterans' Administration. I was the Assistant Chief for the Contact Task Force, 12th District. At that time our great problem was the treatment of tuberculosis. We had no hospitals. We fought for hospitals. We do not have enough hospitals today to take care of the load that is going to be upon us within a few years.

Last month, a Veterans' Administration hospital was damaged in California. This was bad enough, but the loss of those beds isn't something we are going to be very readily able to replace.

I want to thank you for the privilege of being here, sir.

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. Chairman, you are aware that I formed somewhat of a habit of deferring to your views in the other place, and I shan't depart from it now because I find you as compelling a witness as you are a distinguished chairman.

Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

Mr. Miller, you state in your testimony that this hospital is earmarked for closing. Do you know this to be a fact?

Mr. MILLER. All I know is what I read in the newspapers, and the communications I get saying that this hospital, among others, is cited to be closed.

Mr. NELSEN. What communications are you talking about?

Mr. MILLER. Oh, I think we got a news release or a letter saying that these hospitals were going to be closed. It certainly has been carried in the press and other places.

Mr. NELSEN. Now, you would have no objections if by some reorganization these hospitals could be put to maximum use, every bed occupied, would you?

Mr. MILLER. None.

Mr. NELSEN. This is part of the goal that Dr. Egeberg indicated they were seeking. There may be some hospitals that will never be touched other than for improvements. I am sure you will agree this is all right and this would not be ridiculous.

Mr. MILLER. If we put the hospitals to their maximum use, that is all anybody can ask.

Mr. NELSEN. We are in agreement on that score?

Mr. MILLER. Full agreement.

Mr. NELSEN. I think we are going to find some very proper answers in whatever will be done.

Very frankly, we had Dr. Egeberg before our committee for less than 2 hours, which did not give him a good deal of time, and I have made no personal investigations. Also, we are not equipped on the minority side with an adequate staff which could be put to good use for I like to know what all of the facts are.

You will find no one on the minority side that is endorsing the idea that a needed hospital be closed. I am sure you can be at rest.

But at the same time, we will expect you to help us make it a better hospital.

Mr. MILLER. Mr. Nelsen, may I say I am not conscious of the fact that sickness or disease recognizes political parties or political lines. I would agree with you.

So I am not concerned a bit with the minority or the majority. I am concerned with a problem that confronts the country.

Mr. SYMINGTON. Thank you, Mr. Nelsen.

Mr. Kyros.

Mr. KYROS. I wish to welcome our distinguished chairman of the Science and Astronautics Committee.

In keeping with what you said yesterday, Dr. Chase, the Medical Director of the Veterans' Administration said that the occupancy rate of Veterans' hospital beds is over 90 percent, on the average, thoughout the United States, and that they are not in a position to take over these facilities. You are absolutely right when you say that the Veterans' Administration cannot pick up an additional patient load if you should shut down these outpatient clinics and hospitals.

Mr. MILLER. May I say, Mr. Kyros, in that connection that during World War II at a site known as Oak Knoll in Oakland, Calif., the Navy erected a hospital. It was a temporary hospital with wooden buildings. You almost had to have cars to take the doctors around, it is so big.

About 4 years ago, we got some money and erected—the Navy erected—a 650-bed hospital. I think one of the most modern in the country and everything has gone into it. We had hoped that when we got that hospital we could pull down the old wooden shacks and get rid of them.

As a result of the war, every facility, including the new and the old, is being used. I haven't looked at military hospitals like I used to when I was on the Armed Services Committee, but I dare say if you call in the Surgeon General of any of the three services and ask them, you will find that all of their hospitals are crowded to gunnels.

Mr. NELSEN. Odds are that there will be more still, I would presume, with the Vietnam situation.

Mr. MILLER. Certainly, I think there will be.

Mr. KYROS. I think that the other excellent point you made, Mr. Chairman, is that before they seek efficiency and saving money—and I respect the administration's effort in this respect—that they do try to find alternative facilities. They have come before this committee and

have so stated; however, the problem is that studies and surveys have to be made. That is why I think H. Con. Res. 98, of which you are a cosponsor, is a good idea, that is to see if they have the alternative facilities and maybe utilize what we have before they begin to close, stop the money, and cause the staff to leave.

So I want to commend you for a very fine statement, sir.

Mr. MILLER. Thank you very much, sir.

Mr. SYMINGTON. Dr. Carter.

Mr. CARTER. Certainly I want to commend the distinguished chairman. I think he has given a very good dissertation on this and has been very reasonable, very thoughtful.

I want to commend you particularly on the possibility of utilizing the vacant beds for veterans. I think there is no doubt but what our Veterans' hospitals are overcrowded. Not only that, they are not as well equipped as they should be, many of them are not air-conditioned, and I feel that—certainly I feel that we should give them everything that is necessary for their comfort and treatment.

It seems to me that there is a strong possibility that we might utilize these beds. So far as I am concerned, if we can work out something like this for your area or for any area, as far as the closure of the hospital is concerned, I say let not your heart be troubled.

Thank you, sir.

Mr. MILLER. Well, I don't want to be parochial. A sick man is a sick man, no matter where he is.

Could I make a statement off the record?

(Discussion off the record.)

Mr. CARTER. Mr. Chairman, if I might say, after World War II, on October 19, I was one of a group of physicians with a couple of thousand troops who came back on a troop ship, and after a few days out, Dr. Frank Evans of Memphis, Tenn., and I had to do an appendectomy on board one of those ships without air conditioning. But we were real fortunate. The patient got along real nicely. Air conditioning would have been real beneficial at that time.

Mr. MILLER. Doctor, I think as we look back over our wars, the one where your grandfather got his Minié ball and the Spanish War, poor devils with typhoid at that time, on hospital ships that had no air conditioning went through more hell than we can appreciate.

Mr. ROGERS (presiding). Mr. Preyer.

Mr. PREYER. No questions.

Thank you, Mr. Chairman, for your statement.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. No questions.

Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I have no questions.

I want to thank the chairman for his excellent testimony.

Mr. MILLER. Thank you.

Mr. ROGERS. Mr. Chairman, thank you very much. We are very grateful to you.

Mr. MILLER. With your permission, I will go back and take my position at a committee that is now meeting.

Mr. ROGERS. We appreciate the patience of our next witness who has been here through it all, a member of the full committee who has

been most interested in this matter, our distinguished colleague from Texas, Congressman Eckhardt. We appreciate the patience you have exhibited to the committee.

STATEMENT OF HON. BOB ECKHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ECKHARDT. Mr. Chairman, I feel gratified in having the information, since this is an important matter that may come before the full committee.

I have enjoyed the testimony and it also shortens mine. I might ask the chairman, with his permission, to introduce my written statement and make a summary and oral comment.

Mr. ROGERS. The full statement will be made a part of the record, without objection, and we will be pleased to have your comments.

Mr. ECKHARDT. First, Mr. Chairman, I should like to congratulate you and the committee. I understand this is the third day that you have chaired the committee. I know it will be of great benefit to the entire committee.

I would like to address myself to my statement and to some of the remarks that have come from the committee with respect to the question of whether or not the hospitals are fully occupied.

Of course, the hospital facilities which are closest to my region are both the Galveston Hospital and the outpatient clinics at Houston and also at Port Arthur. There is also a very strong relationship to the Houston medical situation in that the large VA hospital which seems to be somewhat envisioned as a receptacle for these patients if changes are made is in Houston, and of course one of the largest medical facilities connected with the military services is at Brooks General San Antonio.

All of these have an interrelationship.

Now, I would like to say with respect to the comments about youth, that it may be that some of these facilities are now very heavily used. But it is my information, which is of recent origin and from our administrative sources at the hospital itself, that the Galveston Hospital is at a level of 80-percent occupancy, averaging 125 patients daily out of a total hospital capacity of 160 patients daily. Of these, there are 96 seamen, seven coastguardsmen, and 14 patients from the Defense Department as average.

Of course, there are other persons in the various categories that make up the difference.

But I cannot see for the life of me why there is any question with respect to this hospital as to its use under its present capacity. Under the CHAMPUS program, for instance, dependents of military personnel are entitled to hospitalization. Not very long ago I received a request from a constituent to do something about a situation in which he had been informed that his dependent mother could receive an operation in a private hospital and be paid for it. This was erroneous information. He was in the Navy. His mother was—it was the night before the operation. At that time she was informed that the private hospital would not be paid under any program, that he would have to put her, if anywhere for free services, in a hospital which was in the nature of a military hospital that could have included the hospital like the Galveston Hospital or Brooks General.

Of course, it was impossible to do that on a notice immediately before the operation, the night before. And the operation proceeded and he is now being billed the full charges for hospitalization in a private hospital in Houston.

I therefore had occasion to check the possibilities of his being able to get his dependent mother in one of the other hospitals, the ones to which he was entitled to service, which would have included, as I understand, facilities like the Galveston Hospital, at least theoretically, whether they had the facility for that operation or not I don't know. But I was informed that the demand on all medical hospitals in the area is so gigantic for military men themselves that the waiting list for dependents is so long that this situation of treatment in such a hospital would have been utterly impossible for this Navy man.

Now, this hospital running at 80 percent capacity, plus the demands under the CHAMPUS program, is obviously inadequate for those presently eligible for attendance there, and as the distinguished chairman of the subcommittee has remarked, the real crux of the matter is that the Public Health Service hospitals are left out of the proposed budget.

Now, if they were in the budget, it may be that hospitals in other places would occupy their facilities with persons outside present eligibility. I have no objection to that, but the point is without the budget this simply means that the naked facilities of the hospital will be available for a community which will have to in some way afford the cost of running them.

Now, I don't know what community is going to pick up those facilities in a short time if these hospitals are so turned over. I have the utmost faith in the subcommittee on both sides of the aisle, that they are concerned about that problem, and from the statements that have been made here by both majority and minority members, I would assume that you will see that these facilities are continued to be financed, certainly to the extent that they may be afforded to those now eligible where the hospital is running about an 80-percent level and where the CHAMPUS program is not being satisfied in the community.

But for the life of me, I cannot see with respect to our facilities where any change at all is needed to fully utilize the facilities.

(Mr. Eckhardt's prepared statement follows:)

STATEMENT OF HON. BOB ECKHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

At a time when this country lingers on the precipice of a health care crisis, and when our citizens are in desperate need of more and better quality medical care, I find it insensible and irresponsible of the Nixon Administration to suggest the closing of the Public Health Service Hospitals.

It was my understanding that Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, last Friday said that the Administration did not intend to close the hospitals, but would instead like to transfer them or convert them to community-use or community-operated hospitals. But, if indeed, this was the intention, why were funds for the Public Health Service Hospitals left out of the proposed budget? Is this another attempt by the Nixon Administration to call a liquidation a "conversion" or "transfer" to appease the opposition? I feel the terms "to transfer" or "to convert" have become euphemisms for "to liquidate."

I, of course, am particularly concerned with the possible closing of the Galveston Public Health Service Hospital and the outpatient clinics in Houston and Port Arthur. The hospital at Galveston serves all the ports of the vast Texas Gulf Coast with its many merchant seamen and federal employees.

Of the eight public health service hospitals, it holds one of the highest percentages of primary patients—80%. All the reports up to last Friday have been to the effect that these facilities were to be closed. And it is cold comfort to say they may not be closed but money to run them will be cut off.

The Galveston hospital also serves patients in underserved areas of its community, admitting an average of 2,550 patients annually and serving about 47,000 outpatients a year while the outpatient clinics serve approximately 32,000 patients yearly.

Since the Galveston hospital works so very closely with the University of Texas' Medical School Branch, dissolving the hospital would debilitate the medical school. This hospital serves as a training ground for medical students. Patients requiring special services can receive them from the Medical Branch.

Each benefits the other and to eliminate the hospital would in essence be upsetting the education and medical experience of these medical students as well as cutting off medical services patients in that vicinity may need.

Rather than eliminate the Galveston hospital, we need to enlarge and modernize it. The Galveston hospital is using trailers to serve its patients and maintain its administrative services. It has an 80% occupancy rate, averaging 125 patients daily, and has a capacity for 160 persons. Among the 125 patients, the hospital has a daily average of 96 seamen, 7 Coast Guardsmen, and 14 patients from the Defense Department. At a recent hearing, the Secretary of Health, Education, and Welfare, Elliot Richardson, said that the modernization of such facilities would be too costly; but certainly it would be more costly to transfer Public Health Service Hospital patients to Veterans' Administration hospitals or private hospitals as Mr. Richardson has suggested, and spend the $100-a-day a private hospital demands per patient. This $100 figure does not include doctors' fees, X-rays, laboratory work, nor drugs while the $47-a-day-per-patient-cost at which the Galveston hospital operates includes all of the above-mentioned.

In addition, the Administration seems to be overlooking—dangerously so—the hard fact that our VA hospitals are already shockingly overcrowded and overburdened. Dr. John Chase of the medical staff of the Veterans Administration yesterday testified to this fact. A spokesman for Houston's VA hospital advised me of the crowded conditions at that hospital and confirmed that it could not handle any additional load of patients. It presently operates at an occupancy rate of 93%, and it is well known that no hospital can properly and efficiently operate completely full. While over 100 patients apply per day for hospitalization at the VA hospital, only 48% of these applications can be accepted. The day a staff member spoke with a VA official, 188 patients were on the waiting list, some having waited for 3–4 months. I am advised that at the Galveston Public Health Service Hospital, no applicant is turned away.

This committee was told by an Administration spokesman that officials visited the eight cities having public health service hospitals. However, I wonder what sort of investigation it was. I am told that the Director of the Galveston Public Health Service Hospital was not called upon to voice his opinion nor was he requested to deliver any information about what this hospital was doing for the community.

Perhaps the Director could have told those officials that, for Galveston Island, closing the PHS means 230 civil service employees out of work. It means they would have to leave the island to find new jobs. I am told that five employees have already left the Galveston hospital in anticipation of the closing of that facility. Four of the five employees, according to a spokesman for the hospital, are "irreplaceable." The hospital has lost a lab technician, doctor, outpatient civil service employee, and an anesthesiologist, and few people are willing to take a professional job that has a precarious future.

Recently the public health service hospitals have assumed new roles in their communities. The Galveston Hospital is no exception. It is participating in several area projects to better serve the community. One of these is the Neighborhood Youth Corps Program where nine high school dropouts are being trained for skilled hospital jobs, and it is anticipated that 15 more may be brought into the program. Last summer, the hospital provided staff and facilities for physical examinations of 180 "disadvantaged" boys.

In addition, the hospital is assisting the Galveston County Coordinating Community Clinic in the establishment of an outpatient clinic for indigents of Galveston County. It is expected that there will be some 40,000 visits there during the year.

Today our nation faces massive unemployment, a failure by government and private industry to supply the services people need to lead a decent life, and

tragic decline in the confidence of the people in their leaders. The closing of these hospitals, while doing nothing to solve any of these problems, will aggravate every one of them. At this moment, the last thing we need is to tell the injured and dying of our nation that their government does not care to provide decent medical care for those who need it most. How can we tell those whose lives and livelihoods depend on the existence of these hospitals that they are expendable?

Mr. ROGERS. Thank you very much, Congressman Eckhardt, for bringing these facts, and I think you have zeroed in on them very well, to show your concern and mine that there is no money in the budget.

Now, we hope we are going to be able to change that.

Mr. ECKHARDT. Well, that certainly concerns me, Mr. Chairman. That is my major concern.

Mr. ROGERS. I agree.

Mr. Nelsen.

Mr. NELSEN. Thank you.

I thank my colleague. I will be down in Texas in a couple of weeks. Is McAllen your district?

Mr. ECKHARDT. Yes, sir. That is where my wife was born.

Mr. NELSEN. Well, I will be in McAllen.

I would like to call to your attention, so that the record is clear, that I asked of Dr. Egeberg—is it possible that the Budget Bureau is awaiting your report before making a recommendation on the budget? He said, this is true, because HEW will have a report, plans to make a report as to what their intentions are after completing their current examination.

So then the question was asked of the gentleman who seemed to have a part in the preparing of the budget, as far as HEW is concerned, if there would be a request submitted, he said there would be. I think that while the exercise of muscle on the part of the Budget Bureau sometimes irritates all of us, I also think we need to kind of keep the door open and try to push in the direction of accomplishing what you want, what we all want, and that is to make these hospitals a more fully usable hospital.

I think we ought to accommodate the situation by law or otherwise to see that it is a community facility that would do the utmost in supplying health services, and I am sure you would agree with this.

I want to thank you for your testimony. It is always very pleasant to be associated with you in the Committee on Interstate, and Foreign Commerce as well as some of our little debates on the floor on tugboats.

Mr. ECKHARDT. A mutual pleasure.

Mr. ROGERS. Congressman Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

I also want to welcome our colleague here, and commend him for his statement. I think what is important is that the statistics provided by the gentleman from Texas, namely, that Galveston Hospital has an 80-percent occupancy rate, and the Veterans' hospitals in the area are running at 93 percent, indicate that apparently there would not be alternative facilities if you did anything to the hospital and the two outpatient clinics; is that so?

Mr. ECKHARDT. That is correct. I have placed in my statement the level of occupancy at 93 percent in the VA hospital, and of course 93 percent really means that it is fully occupied, because that amount of margin is necessary in a hospital. There are, in fact, only 48 percent of

the applications to the VA which are accepted. If one is in a position which I am sure you are familiar with of representing a number of constituents seeking services there, you know that we receive a reflection of the crying need for treatment in the Veterans' Administration hospitals that are not presently being met, persons with chronic heart disease, diabetes, things in which periods of hospitalization are desirable.

But the person is treated wholly as an outpatient and then with not adequate time to give him the attention necessary.

Certainly the Veterans' hospitals as it is known to every Member of Congress are terribly overcrowded.

Mr. KYROS. Could I ask you this, Mr. Eckhardt, are there other public or private medical facilities other than the VA hospitals which could provide medical services in the event the Public Health Service Hospital and the clinics were shut down?

Mr. ECKHARDT. Well, as the gentleman knows, as one of the largest medical facilities, total medical facilities in Houston, of any place in the country connected with Baylor University and the University of Texas will have a branch there shortly. It already has its dental branch and it has also the M. D. Anderson Hospital dealing with tumors and cancer.

There are extensive hospital facilities in the Houston area, but as everywhere, these are under great demand and the cost of usage is extremely high. I would say that $100 a day is about the running hospital room rate, and it would seem the most wasteful possible approach to close down an existing hospital with an experience of much less than that cost per day per bed, and put these persons in private hospitals, thus additionally loading facilities.

Then, too, of course we have got to consider the fact that the facilities at Galveston also affords clinical opportunities to the University of Texas Medical Branch at Galveston, and though there are extensive hospital facilities in Houston, the facilities in Galveston are at least not as large totally. I would not say that they are under any greater demand than the Houston facilities. But it would seem very shortsighted to cut those facilities down at that time.

Mr. KYROS. Thank you.

Thank you very much, Mr. Chairman.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Mr. Chairman, I regret the gentleman has brought a political note into this.

Mr. ECKHARDT. I had not noticed.

Mr. CARTER. He has mentioned that the Nixon administration—"I find it insensible and irresponsible of the Nixon administration to suggest the closing of the Public Health Service hospitals."

I wonder if he regards such action by any administration as being insensible and irresponsible?

Mr. ECKHARDT. I certainly would. Had it been done by the Johnson administration, I would have said it.

Mr. CARTER. This was done, of course, under President Johnson's administration in 1965. The hospitals in Chicago and also in Memphis were closed.

Mr. ECKHARDT. If that were done and if the circumstances were similar to these——

Mr. CARTER. Well, I assure you that it was done, and you, by the same note, we must indict the previous administration for the same thing.

I thank you for the statement, Mr. Chairman.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. No questions.

Mr. ROGERS. We appreciate very much your testimony. Also, I think it has already been brought out in the hearings, in the report that HEW has now submitted for the committee that the University of Texas at Galveston says if this hospital is closed they will have a reduction of 20 percent in the training that they can do for medical personnel.

Mr. ECKHARDT. I think that is very, very——

Mr. ROGERS. It is very significant.

Mr. ECKHARDT (continuing). Important, because one thing is when you are talking about merchant marine personnel, when you are talking about the kind of personnel available here, you are not talking just about Galveston. You are talking about drawing them from that whole population area, and the school at Galveston does very badly need clinical facilities.

Mr. ROGERS. Thank you so much.

The committee appreciates your appearing here today.

Thank you.

Our next witness, and we will try to do this quickly, if we may, is from the Comptroller General of the United States, Mr. Paul G. Dembling, the General Counsel. I understand he is accompanied by Mr. John W. Moore, Assistant General Counsel, and Mr. Robert P. Wade, Attorney Adviser.

We welcome you gentlemen and appreciate your being here.

STATEMENT OF PAUL G. DEMBLING, GENERAL COUNSEL, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JOHN W. MOORE, ASSISTANT GENERAL COUNSEL; AND ROBERT P. WADE, ATTORNEY ADVISER

Mr. DEMBLING. Thank you, Mr. Chairman.

In order to conserve time, I could very briefly summarize my brief statement.

Mr. ROGERS. I think that would be fine, and your statement will be printed in full in the record, without objection.

Mr. DEMBLING. Thank you.

As you know, the proposed closings have been the subject of two legal opinions rendered by the Comptroller General; one in June 1965 and the most recent one on February 23 of this year. Last month's opinion was rendered to the chairman of the House Committee on Merchant Marine and Fisheries, in response to his request for our current views on this matter. I have copies of this opinion, as well as the 1965 opinion, if you wish to enter those in the record. [See p. 193, this hearing.]

Mr. ROGERS. I think it would be well to have those with your statement, without objection.

Mr. DEMBLING. As was made clear in those opinions, we would view action by the Department of Health, Education, and Welfare to close down the entire Public Health——

Mr. ROGERS. Excuse me a moment.

I wonder if you have any extra copies of the February 23 opinion with you? I think Congressman Kyros would like to have one, and the others, if you have them. I have one here. Maybe you could share that with Congressman Symington.

Excuse me. Proceed.

Mr. DEMBLING. As was made clear in those opinions, we would view action by the Department of Health, Education, and Welfare to close down the entire Public Health Service hospital system as an unwarranted extension of the legal authority contained in the Public Health Service Act of 1944 under which the Secretary operates and manages these facilities. We pointed out generally that the legislative history of the Public Health Service system, going back to 1798, indicated that the intent of the Congress throughout the years was to maintain a public health service system.

Whether the Public Health Service should be authorized to close the marine hospitals, of course, is a matter of policy for the Congress to determine and one on which we would make no recommendation. We agree, however, that the resolutions under consideration by your committee which express the sense of the Congress that the present Public Health Service hospital system be maintained and considered as an integral though small part of the Nation's medical care facilities are consistent with present law and with the long history of the Public Health Service hospital system in this Nation.

Thank you very much, Mr. Chairman.

(Mr. Dembling's prepared statement follows:)

STATEMENT OF PAUL G. DEMBLING, GENERAL COUNSEL, GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the subcommittee: We appreciate this opportunity to appear before your subcommittee to present our views on H. Con. Res. 98 and similar resolutions on the proposed closings of the Public Health Service Hospitals by the Department of Health, Education, and Welfare. The purpose of these resolutions is to express the sense of the Congress that the existing facilities be maintained for the present and be considered as an integral part of the nation's health delivery system.

As you know, the proposed closings have been the subject of two legal opinions rendered by the Comptroller General; one in June, 1965 and the most recent one of February 23, of this year. Last month's opinion was rendered to the Chairman of the House Committee on Merchant Marine and Fisheries, in response to his request for our current views on this matter. I have copies of this opinion, if you wish to have it inserted in the record.

As was made clear in those opinions, we would view action by the Department of Health, Education, and Welfare to close down the *entire* Public Health Service hospital system as an unwarranted extension of the legal authority contained in the Public Health Service Act of 1944 under which the Secretary operates and manages these facilities. In our view such action by the Secretary would run contrary to the intent of the Congress as manifested in the 1944 act. As we indicated in our February 23d letter, that Act codified then existing Public Health Service laws which trace their origin back to 1798, at which time authority was given to the President to construct the first Marine hospital.

There are numerous indications in the 1944 Public Health Service Act that the Congress intended the Public Health Service to continue to operate and

maintain its own medical facilities. The act is replete with references to the "institutions, hospitals, and stations of the Service." Section 321 provides authority to the Secretary to operate and maintain Public Health Service hospitals.

Section 322 sets forth the obligation of the Secretary to care for seamen and other listed beneficiaries at Service institutions, hospitals, and stations; section 301 provides authority to admit and treat at "hospitals and stations of the Service" persons not otherwise eligible, for purposes of study; Section 324 confers authority on the Secretary to provide medical, surgical, and hospital services and supplies to Bureau of Employee Compensation beneficiaries, another authority that can only be exercised at institutions, hospitals, and stations of the Service; section 326 entitles certain Coast Guard personnel and public health services officers to medical and surgical treatment and hospitalization by the Service; provision is also made for treatment of narcotic addicts and persons afflicted with leprosy at specially equipped Service hospitals (sections 331, 341, and 344), and section 328 provides for the sharing of facilities and resources by the Public Health Service hospitals and other community health care facilities. It seems clear that these provisions would be inoperable and meaningless in the absence of institutions, hospitals, and stations of the Service, and that there is no reasonable way to read these provisions except as imposing an obligation on the Secretary to establish and maintain such facilities for the care of those who are by the statute entitled to it.

Moreover, as pointed out in our February 23 opinion, this interpretation of the 1944 Public Health Service Act is the only one in accord with the long history of the predecessor of the Public Health Service, the Marine Hospital Service, which was established by the act of July 16, 1798. This act conferred authority on the President to construct hospitals specifically for seamen. The legislative history of that act clearly indicates that the construction of a marine hospital system was contemplated. As we stated in our letter of February 23, 1971, the obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide such care have been characteristic of the Public Health Service ever since the passage of the 1798 act. In enacting the 1944 Public Health Service Act, it seems clear that the Congress assumed the continued maintenance of the existing system as a necessary condition to the effective implementation of the act's essential provisions, as I have just outlined.

It should also be noted that in a legal opinion by the Assistant General Counsel of the Department of HEW dated December 17, 1963, he stated:

> "We would thus conclude that there is no question but that the Public Health Service Act represents the congressional intent that a hospital system be operated and maintained by the Service to carry out the obligations imposed by or implicit in the several statutory provisions noted."

With respect to the authority of the Veterans Administration to provide care for beneficiaries of the Public Health Service, we pointed out in our February 23rd letter that we see no legal objection to periodic arrangements for cross-servicing of VA and Public Health Service beneficiaries. Since merchant seamen are not beneficiaries of the VA, the admission of merchant seamen to VA hospitals would involve interagency services under section 601 of the Economy Act of 1932, 31 U.S.C. 686, which authorizes Federal departments and agencies to place orders for goods and services with other Federal agencies on a reimbursable basis. Section 601 also requires that the requisitioned Federal agency be in a position to provide the services requested, which has been construed by the Comptroller General to mean that the rendering agency can do so without necessitating construction or other capital expenditure which would be unnecessary if the requested services were not to be provided. In view of this and the fact that under 38 U.S.C. 611 the Administrator of the VA may furnish hospital care to non-VA beneficiaries as a humanitarian service in emergency cases, it is generally recognized that Public Health Service beneficiaries may under such circumstances be admitted to VA Hospitals on a space available basis.

However, providing such services under the Economy Act is at best a secondary or incidental function of the agency rendering the service and section 601 certainly was not intended to be a basis for transferring a primary administrative function from one agency to another. Accordingly, the VA could not assume overall responsibility for Public Health Service beneficiaries under such authority.

Whether the Public Health Service should be authorized to close the marine hospitals is a matter of policy for the Congress to determine and one on which

we would make no recommendation. We agree, however, that the Resolutions under consideration by your Committee, which express the sense of Congress that the present Public Health Service Hospital System be maintained and considered as an integral, though small, part of the nation's medical care facilities are consistent with present law and with the long history of the Public Health Service Hospital System in this nation.

(The Comptroller General's opinions referred to follow:)

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., June 7, 1965.

Hon. HERBERT C. BONNER,
Chairman, Committee on Merchant Marine and Fisheries,
House of Representatives.

DEAR MR. CHAIRMAN: Your letter dated April 13, 1965, requests our views on several legal questions which arose during the recent hearings of your committee on the proposed administrative closing of designated Public Health Service hospitals, announced January 19, 1965, by the Secretary of Health, Education, and Welfare.

To briefly summarize the situation, the Department of Health, Education, and Welfare contemplates closing, over the period ending with the fiscal year 1968 or 1969, seven of the twelve general hospitals of the Public Health Service. The hospitals to be closed are in Chicago, Memphis, Savannah, Boston, Galveston, Norfolk and Detroit. They are the smallest of the Service's general hospitals, having a capacity of 1,035 beds, or approximately 35 percent of the present bed capacity of the twelve hospitals.

The closed hospitals are to be converted to outpatient clinics which will refer Public Health Service beneficiaries in need of hospitalization to Veterans Administration, Department of Defense, or local community hospitals. Merchant seamen, the largest category of Public Health Service beneficiaries, are to be referred to Veterans Administration hospitals, and it is contemplated the Veterans Administration will give the merchant seamen a higher priority in admission to its hospitals than veterans with nonservice-connected disabilities.

The five remaining Public Health Service hospitals, located at Staten Island, Baltimore, New Orleans, San Francisco, and Seattle, are to be modernized and enlarged from a bed capacity of 1,937 to not more than 2,400, or an increase of about twenty percent. In the course of the hearings your committee was informed that a study was being conducted, by the Office of Science and Technology, to weigh the merits of transferring responsibility for the health care of American seamen, and the five remaining Public Health Service general hospitals, to the Veterans Administration.

In view of the foregoing the questions arose, on which our opinion is requested, "as to the authority of the Department of Health, Education and Welfare to close any or all of the Public Health Service hospitals and to transfer a statutory responsibility to another government ageucy." Also, "The questions arose as to the authority of the Veterans Administrator to render hospital care to Public Health Service beneficiaries in preference to veterans of any category and under what authority, if any, can nonveterans be treated at Veterans Administration hospitals."

The Public Health Service Act, as amended (42 U.S.C. 201, *et seq.*), contemplates the operation by the Public Health Service, Department of Health, Education, and Welfare, of hospitals and other stations for the care of certain beneficiaries, such as merchant seamen, and in the absence of Public Health Service facilities authorizes the referral of such beneficiaries, at the expense of the Service, to public or private hospitals. S. 249. The act also states that any executive department, in accordance with the interdepartmental service provisions of 31 U.S.C. 686, may perform work or service for the Public Health Service, § 254.

The Surgeon General, who administers the Public Health Service, is empowered by the Public Health Service Act to "control, manage, and operate all institutions, hospitals, and stations of the Service * * *." § 248(a). Our examination of the act does not disclose a substantive basis for restrictively construing the general administrative powers thus conferred. Rather, in the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to outpatient clinics one or more

of the Service's general hospitals. The closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority.

While we consider the proposed conversion of the seven smallest hospitals to outpatient clinics to be within administrative authority where the treatment of Public Health Service beneficiaries may otherwise be provided, we do not view the contemplated interdepartmental transfer of the remaining five Public Health Service hospitals, together with responsibility for the health care of merchant seamen, as encompassed by that authority. The accomplishment of the latter transfer of facilities and responsibility would require a Reorganization Plan, in the event the Reorganization Act is extended beyond June 1, 1965, or a legislative enactment. This view of the matter we understand is also entertained by the Department of Health, Education, and Welfare.

In considering your questions with reference to the rendering of hospital care by the Veterans Administration to nonveterans, we particularly noted the memorandum dated March 25, 1965, of the Assistant General Counsel, Veterans Administration, which appears on page 227 of your Committee's hearings. We concur in his position that the Veterans Administration may furnish, in accordance with the provisions of 31 U.S.C. 686, hospital care on a reimbursable basis to beneficiaries of other Federal agencies where facilities are available.

Section 686 provides for interagency furnishing, on a reimbursable basis, of "material, supplies, equipment, work, or services of any kind that [the] requisitioned Federal agency may be in a position to supply or equipped to render * * *." In concluding that the Veterans Administration may furnish hospital care to nonveterans on a space available basis under a section 686 arrangement, we have not overlooked the existence of section 5003 of Title 48, United States Code, authorizing the Veterans Administration and the Armed Forces to enter into "contracts for the mutual use or exchange of use of hospitals and domiciliary facilities, and such supplies, equipment, and material as may be needed to operate such facilities properly, or for the transfer, without reimbursement of appropriations, of facilities, supplies, equipment, or material necessary and proper for authorized care for veterans." Section 5003 is in effect an extension of the scope of section 686 in that it provides for the mutual use or exchange of hospitals and the transfer of such facilities, etc., without reinbursement. Section 5003 is not in conflict with section 686, and is not viewed as precluding resort to the interagency service provisions of the latter.

However, the use of section 686 would require the Veterans Administration to be in a position to supply or equipped to render the requested services. See 23 Comp. Gen. 935. And we are of the opinion that the situation of being in a position to render service cannot be artificially created by the promulgation of an administrative regulation, under 38 U.S.C. 621, which would subordinate statutory beneficiaries of the Veterans Administration to beneficiaries of other agencies and constitute a relinquishment of the Veterans Administration's primary responsibility. See 38 U.S.C. 201, 610, and 5003; *United States* v. *St. Paul Mercury Indemnity Company*, 133 F. Supp. (1955) 726, 735, 736, affirmed 238 F. 2d 594; *United States* v. *Alperstein*, 183 F. Supp. (1960) 548, affirmed 291 F. 2d 455.

We believe the foregoing answers the questions submitted but we shall be pleased to consider any additional aspects you may wish to explore.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., February 23, 1971.

Hon. EDWARD A. GARMATZ,
Chairman, Committee on Merchant Marine and Fisheries,
House of Representatives.

DEAR MR. CHAIRMAN: Reference is made to your letter of January 25, 1971, directing our attention to a legal memorandum dated January 21, 1971, by the General Counsel of the Department of Health, Education, and Welfare which concludes that HEW does have authority to close existing public health service hospitals and clinics throughout the country. You cite our letter of June 7, 1965, to the Chairman, Committee on Merchant Marine and Fisheries, holding to the contrary, and ask our current views on this and the other questions posed and answered in the HEW memorandum.

The questions considered in the HEW memorandum are stated as follows:

"1. Does the Secretary of Health, Eductalon, and Welfare have the authority to transfer PHS hospitals and out-patient clinics to non-federal owners?

"2. Does the Secretary of Health, Education, and Welfare have the authority to provide for the care of Public Health Service (PHS) beneficiaries at facilities other than those operated by the PHS?

"3. Can PHS beneficiaries be given priority in Veterans Administration (VA) hospitals ahead of veterans with non-service-connected disabilities?

"4. Can VA and PHS make cross-servicing arrangements to provide for the care of each other's beneficiaries?"

1. *Authority to Transfer PHS Facilities to Non-Federal Owners (Closing of PHS Hospitals).*

In our decision of June 7, 1965, holding that the closing of *all* Public Health Service general hospitals was beyond the discretionary authority of the Department, we stated:

"The Surgeon General, who administers the Public Health Service, is empowered by the Public Health Service Act to 'control, manage, and operate all institutions, hospitals, and stations of the Service * * *' (sec. 248(a)). Our examination of the act does not disclose a substantive basis for restrictively construing the general administrative powers thus conferred. Rather, in the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to out-patient clinics one or more of the Service's general hospitals. The closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority."

We find nothing in the HEW memorandum that would persuade us to reach a contrary view at this time. The essential thrust of the HEW memandum is to the effect that the early statutory authority to which the PHS hospital system owes its existence intended contractual arrangements to be the primary basis for seamen medical care, and that the building and continued maintenance of a Federal hospital system was not contemplated. We cannot agree that such a system was not contemplated.

The PHS hospital Service traces its origin to the act of July 16, 1798, for the relief of sick and disabled seamen, 1 Stat. 605, which provided authority to the President to (1) receive donations of buildings or land upon which hospital buildings could be erected (section 4), (2) to erect hospital buildings specifically for the care of sick and disabled American seamen (sections 3 and 4), and (3) to appoint Directors of the "marine hospital of the United States" (section 5).

The legislative history of the 1798 act indicates clearly that the construction of a marine hospital system was contemplated. One of the principle grounds of congressional opposition to the bill was the fear that costs of the hospital system authorized to be constructed would outweigh the benefits to be derived from such a system. See *Annuals of Congress*, 5th Congress, 1797–1799 Vol. II pp. 1386–1392, containing the following remarks excerpted from the House debate on the bill:

"Mr. SEWALL said * * * the tax will fall upon no member of this House, but will be exclusively drawn from the earnings of a small part of the community, who, in all probability, will receive no advantages from it for fifty years to come as large and splendid buildings must first be erected, in order to exhibit to the world a specimen of public charity. (*Id.* p. 1386.)

"Mr. PINCKNEY was sorry to differ from his friend from Massachusetts * * *. Relief to distress is the first thing to be attended to, and if after affording this relief, the tax produces a sufficient surplus, it is to be employed in the erection of suitable, not large and splendid—buildings, as hospitals. (*Id.* p. 1387.)

"Besides, said Mr. S., this bill proposes the erection of public hospitals * * *. (*Id.* p. 1389.)

"Mr. GALLATIN said * * * [I]nstitutions of the kind recommended in this bill might be used in other countries * * *. How far marine hospitals had been useful in Europe he could not tell; he knew there were many rotten public institutions of hospitals, etc., there * * *. There was one part of the bill which he said he could not consent to vote for, viz: That part which directs the erection of buildings, as he was convinced that persons of every description may be better relieved by being dispersed through the country, than by being placed in a hospital." (*Id.* p. 1392.)

Also worth noting are the numerous references throughout the Congressional Record describing the bill as one providing for the support or erection of marine hospitals, See *id.* pp. 1345, 1383, 1386.

The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since the passage of the 1798 act, and, on the basis of this act numerous hopsitals were constructed and maintained throughout the country during the 19th and 20th centuries.

In 1861, Secretary of the Treasury Chase found that the number of marine hospitals "has been increased far beyond necessity or utility." Secretary of Treasury, Annual Report, 1861, p. 27. Subsequently, as noted in the HEW memorandum, the Secretary was authorized under the act of April 20, 1866, Revised Statutes, as amended June 27, 1866, section 4806, to sell or lease such marine hospital buildings and lands as he deemed advisable. Most important to note, however, is the fact that Congress in giving such authority insured that the basic hospital system would be maintained by prohibiting the sale or lease of the hospitals at Portland, Maine, and Cleveland, Ohio, and provided that no hospital would be sold or leased if the relief furnished amounted to twenty cases a day. Moreover, only a few years later Congress passed the act of June 29, 1870, 16 Stat. 169, providing for a central administrative agency for the Marine Hospital Service and for the appointment of a supervising surgeon who was to supervise "all matters connected with the Marine Hospital Service," thereby making clear its intent that the hospital system continue to be maintained.

Today, under the Public Health Service Act of 1944, 42 U.S.C. 201 *et seq.*, the statutory basis for the continued maintenance of the PHS hospital system, in our opinion, remains. We agree with the view expressed in the HEW memorandum that the Congress in enacting the 1944 act assumed that the then existing PHS facilities would continue to be utilized, and thus maintained. (See page 7.)

A reading of the act shows it to be replete with references to the PHS hospital system and that a major portion of that law's provisions would be inoperable absent such a system. In reaching this conclusion, we are in agreement with a legal opinion prepared by Assistant General Counsel E. J. Rourke, Department of HEW dated December 17, 1963, and published in the 1965 Hearings on the proposed closing of PHS Hospitals before the Committee on Government Operations. In relevant part, the opinion states as follows:

"As indicated below, this conclusion rests in part upon a specific provision in the Public Health Service Act and more broadly on a variety of indications in that act that Congress intends the PHS to operate its own medical facilities. We do not think this intention is substantively qualified by the fact that provision is also made in the Public Service Health Act for the Service to obtain care for certain of its beneficiaries at other public or private facilities at Service expense.

"We may begin with the obligation of the Surgeon General to care for seamen and the other listed beneficiaries 'at hospitals and other stations of the Service' (Public Health Service Act, sec. 322(a)). We know of no reasonable way to read this provision except as imposing an obligation on the Surgeon General to establish and maintain medical facilities of the Service for the care of those who by statute are entitled to it. This literal reading of the provision is the only one in accord with the long history of the Marine Hospital Service which began in 1798 with an authority to construct hospitals specifically for the seaman beneficiary. The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since.

"There are other provisions of the Public Health Service Act which are not operable in the absence of Service hospitals, institutions and stations. Thus the authority to admit and treat for purposes of study persons not otherwise eligible is an authority that can be exercised only at institutions, hospitals and stations of the Service (sec. 301(f)). Also, the authority to provide medical, surgical, and hospital services to BEC beneficiaries can be exercised only at institutions, hospitals, and stations of the Service (sec. 324). Finally, the authority to provide for narcotic addicts may be exercised only at hospitals of the Service (sec. 341). While these provisions do not require the exercise of the authority conferred, it seems obvious that Congress intended the authority to be exercised in appropriate situations; to this extent, appropriate medical facilities of the Service are required.

"Finally, there are other statutory provisions that certainly contemplate the operation of an appropriate PHS hospital system. Examples are the Surgeon

General's authority to manage and operate hospitals and to establish new ones (sec. 321), the authority to care for certain persons at hospitals of the Service where detained by Immigration authority (sec. 502), and the authority to admit into any hospital, institution, or station of the Service insane persons entitled to Service treatment (sec. 504).

"*We would thus conclude that there is no question but that the Public Health Service Act represents the congressional intent that a hospital system be operated and maintained by the Service to carry out the obligations imposed by or implicit in the several satutory provisions noted.* (Italic added.)

"The fact that legal authority is given to the Service under section 322(e) to procure care at other than its own facilities in the case of specified beneficiaries, in our view does not reflect a congressional intention to offer the Service an alternative to the operation of its own hospital system. Rather this is a supplemental authority designed to assure prompt and adequate medical care to selected beneficiaries where Service facilities are not available. This conclusion is clearly supported first by the terms of the act which call for authorization by the medical officer in charge on application—an individualized determination. It is also supported by the legislative history of section 322(e).

"Thus in codifying the statutes relating to PHS in 1944, the significant committee report, that of the House, stated with respect to this subsection:

"'Subsection (e) would authorize treatment of Service beneficiaries in other hospitals, at the expense of the Service, as provided in regulations. This provision, which would afford a statutory basis for present regulations, is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility.'"

As indicated in Mr. Rourke's opinion, 42 U.S.C. 248(a) charges the Secretary with the management and operation of "all institutions, hospitals, and stations *of the service*" (emphasis added), and authorizes the Secretary, with Presidential approval, to "select sites for and establish institutions, hospitals, and stations" as deemed necessary. We find no provision in the act which authorizes the Secretary to close down the entire PHS hospital system by means of the sale or lease of all Service institutions, or by means of the utilization of contractual medical care arrangements.

With respect to the argument raised by the Department that the Federal Property and Administrative Services Act of 1949 authorizes the Secretary to transfer all hospital facilities to nonfederal ownership should he find such properties to be excess to the needs of the Department, we cannot agree.

"Excess property" is defined in the act, 40 U.S.C. 472(e), as property of a Federal agency "not required for its needs and the discharge of its responsibilities, as determined by the head thereof." We find nothing in the legislative history of the Federal Property and Administrative Services Act to suggest that the Congress intended the authority to dispose of excess property to be used by a Federal agency as a means of relieving itself of its statutory responsibilities. In our view, the utilization of such act as a vehicle for closing down the entire PHS medical facility system, and thereby effectively terminating the hospital medical care role performed by the PHS for the past 170 years, would be wholly inappropriate. Such action would relieve the agency of the function of maintaining a hospital system which, as we have shown above, has heretofore been considered by the Congress to be an essential statutory responsibility.

It is therefore our opinion that under the 1944 Public Health Service Act, the Congress intended that the hospital system characteristic of the Service since its inception in 1802 with the Marine Hospital is to be operated and maintained by the Service in order to carry out the functions and duties imposed by the 1944 act. In light of the foregoing, the Secretary may not, in our view, use his discretionary powers under the 1944 Public Health Service Act or the Federal Property and Administrative Services Act of 1949 to effect the closing of *all* PHS hospital facilities by means of the transfer of these institutions to nonfederal ownership.

2. Authority to Provide for Care of PHS Beneficiaries in other than PHS Facilities.

Consistent with the foregoing, we stated in our June 7, 1965, decision that the Public Health Service Act "in the absence of Public Health Service facilities authorizes the referral of such beneficiaries, at the expense of the Service, to public or private hospitals (42 U.S.C. 249)." As pointed out above, the legislative history makes clear that this provision is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility. 78th Congress,

House Rept. 1364, April 28, 1944, on H.R. 4524. Accordingly, we would see no legal objection to the referral of PHS beneficiaries to other public or private facilities, under such limited circumstances.

3, 4. Priority of PHS Beneficiaries in VA Hospitals and Authority to Arrange for Cross-servicing of VA and PHS Beneficiaries.

Regarding the priority of PHS beneficiaries in VA hospitals, we stated in a letter dated June 22, 1965, copy enclosed, to Chairman Fountain, Intergovernmental Relations Subcommittee, House Committee on Government Operations, that the rendering of a service by an agency under section 601 of the Economy Act of 1932, 31 U.S.C. 686, which authorizes Federal departments and agencies to place orders for goods and services with other Federal agencies, if it can be considered a function of the agency rendering the service, is at best a secondary or incidental function, and that section 601 certainly was not intended to be a basis for transferring a primary administrative function from an agency in which it is vested by Congress.

Since by statute the primary function of the PHS is to provide care for seamen and that of the VA to provide care for veterans, we could not then, and do not now, see a legal basis for admitting merchant seamen to VA hospitals ahead of veterans eligible for treatment of nonservice-connected disabilities.

Regarding the authority to arrange for cross-servicing of VA and PHS beneficiaries, we stated in our June 22, 1965, letter that the admission of merchant seamen to VA hospitals would involve interagency services under 31 U.S.C. 686, since merchant seamen are not beneficiaries of the Veterans Administration, and that "except as a humanitarian service in emergency cases," the Administrator of Veterans Affairs would otherwise not be authorized to admit merchant seamen. See 38 U.S.C. 610, 611. Acordingly, and provided that the VA is "in a position to supply or equipped to render" the services requisitioned in accordance with the requirements of section 601 of the Economy Act, we see no legal objection to periodic arrangements for cross-servicing of VA and PHS beneficiaries.

We trust that the above is responsive to your request.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

Enclosure.[1]

Mr. ROGERS. Thank you very much.

Now, let me ask this, Mr. Dembling, is an opinion, an official opinion by the Comptroller General binding on governmental departments?

Mr. DEMBLING. The opinions of the Comptroller General are binding on the executive branch of the Government, yes, sir.

Mr. ROGERS. This has been set forth in court cases, I believe?

Mr. DEMBLING. It has been set forth in the statute under which the Comptroller General operates.

Mr. ROGERS. Would you let us have those citations and make that a part of your testimony, please?

Mr. DEMBLING. Yes, we will be happy to.

Mr. ROGERS. For the record, because the Controller of HEW said as far as he was concerned it was just one man's opinion as against another man's opinion and this committee does not share that feeling of the Controller of HEW, because it is definitely our feeling that, as far as I know, the Comptroller General's opinion is binding opinion.

(The following statement was received for the record:)

STATEMENT REGARDING AUTHORITY OF COMPTROLLER GENERAL DECISIONS

Section 71 of title 31, United States Code, provides that:

"* * * all accounts whatever in which the Government of the United States is concerned, either as debtor or creditor, shall be settled and adjusted in the General Accounting Office." Section 74 of title 31, United States Code, provides that:

[1] Enclosure not printed.

"Balances certified by the General Accounting Office, upon the settlement of public accounts, shall be final and conclusive upon the Executive Branch of the Government * * *.

"Disbursing Officers, or the head of an executive department, or other establishment not under any of the executive departments, may apply for and the Comptroller General shall render his decision upon any question involving a payment to be made by them or under them, which decision, when rendered, shall govern the General Accounting Office in passing upon the account containing said disbursements."

The final and conclusive settlement of public accounts under the cited authorities does not purport to operate as a legal determination of the rights of any of the parties involved. Its purpose is solely to state with finality the status of public accounts thereby dictating the necessity for further action to be taken wherever an account is not cleared.

Because of the consequences of a disallowance upon account settlement, the Comptroller General may render advance rulings on questions concerning the property of payments proposed to be made. These advance rulings may be provided upon his own motion or in response to requests from accountable officers concerning vouchers before them for action or in response to requests from the heads of Government agencies. Advance rulings by the Comptroller General state, in effect, whether a proposed payment will, if made, be approved in connection with settlement of the related account. They are binding upon the General Accounting Office in the sense that an accountable officer may not be held responsible for a payment which the Comptroller General has ruled favorably upon in advance.

Mr. ROGERS. Now, let me ask this: As I understand from your opinion, the fact that an alternative may be provided, in other words, that they might procure care in other than our own Public Health Service hospital facilities, does not relieve the obligation to maintain the hospital system, as such, set up, but that is simply an alternative method to assure quick care, so that if they could not be taken care of at public hospital care systems, they could in those emergencies be taken care of at other facilities?

Mr. DEMBLING. That is correct, sir.

Mr. ROGERS. So the idea of contracting out this whole thing is simply not possible under the law?

Mr. DEMBLING. We haven't directed ourselves to contracting out completely, since this was a new development as a result of Doctor Egeberg's testimony. We did consider the proposition of whether the Public Health Service hospitals could be considered excess property. In the opinion we indicated with respect to the argument raised by the Department, that the Federal Property and Administrative Services Act of 1949 authorizes the transfer of all hospital facilities to non-Federal ownership should the Secretary find such property to be in excess to the needs of the Department and the Administrator of General Services determines that no other Federal agency needs the property.

We couldn't agree with that argument since "excess property" is defined in the act as specific property, not required for the needs of an agency and discharge of its responsibilities as determined by the head thereof. Since the Secretary has a statutory responsibility to maintain a hospital system, we felt that the excess property route was not a way of divesting himself completely of the hospital system.

Mr. ROGERS. Thank you very much.

Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

As I understand it, you referred on page 2 to maintain Public Health Service in toto. Now, what did you mean by in toto? Did you mean

Public Health Service facility as presently exists should be maintained in toto? Is that what you were meaning?

Mr. DEMBLING. No, sir. What I meant, Mr. Nelsen, was that as we interpreted the Public Health Act of 1944 and its prior legislative history there was a statutory responsibility on the part of the Secretary of HEW to maintain a system, and that to close down the entire system was an unwarranted extension of this authority.

Mr. NELSEN. Then you are saying in the event that—well, say two or three hospitals were to be closed, the rest to be kept open, you would recognize this as being a decision that could be made and would not be an illegal process; is that right?

Mr. DEMBLING. It would appear to be so.

Mr. NELSEN. Providing the services supplied?

Mr. DEMBLING. It would appear to be so. It would depend on what the sense of the Congress was as to what is a "system." How many hospitals could be closed and still maintain a system would be a determination to be made, yes, sir.

Mr. NELSEN. How long have you been with the service, in the present position you are in?

Mr. DEMBLING. I have been with the Office of the Comptroller General for about a year and a half.

Mr. NELSEN. I see. What has been the ruling of this office in the case of the prior closings of other hospitals? What has the decision been at that time? Is it consistent?

Mr. DEMBLING. In 1965, when the same proposal was made to close down the Public Health Service hospitals, the same decision was made.

Mr. NELSEN. In other words, what you are saying is that your office has indicated that HEW must maintain Public Health Service hospitals, but also that there may be some areas where adjustments can be made. It is your feeling that where the need exists the hospital should continue to provide the service?

Mr. DEMBLING. Generally. We haven't gone into the substantive need of the hospitals, per se. What we have done is to look at the law under which the system operates and said that the sense of the Congress over the many years was that there would have to be a system maintained. How large that system has to be is for determination.

Mr. NELSEN. Yes.

Thank you. No more questions.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

One or two questions, Counselor.

If a Secretary of Health, Education, and Welfare, advised by his general counsel, says he assumes he has the power to close the hospitals and you say, from your Office of the Comptroller General, that the provisions impose an obligation on the Secretary to maintain or keep the hospitals open, then what happens in that kind of situation? Who makes the ultimate decision?

Mr. DEMBLING. Well, you have a situation here which is unusual because, normally, the opinions of the Comptroller General go to the disallowance of the expenditure of funds.

Mr. KYROS. Precisely. What happens if the Secretary of Health, Education, and Welfare, in the executive department, suddenly ordered the closing of the hospitals tomorrow, although he hasn't—I am just

assuming this as a hypothesis—but what if he did, what would that mean in the light of your opinion?

Mr. DEMBLING. I don't think that we could enforce any action against such action by the Secretary.

Mr. KYROS. All right. You couldn't. Could any other citizen, or could the Congress, act to obtain a restraining order, or perhaps a mandamus, in regard to the executive department, in your judgment?

Mr. DEMBLING. It has happened in other areas, for example, in the contracting area—in the Government procurement area. Losing bidders have gone into the courts under the recent standing to sue cases, and have obtained temporary restraining orders and injunctions.

Mr. KYROS. I know, but the closings of hospitals would involve judgment and discretion. Our testimony could only be if the closings were capricious, arbitrary, and perhaps fraudulent. This is different than a contract case?

Mr. DEMBLING. Yes.

Mr. KYROS. I am not saying the administration is going to do this, because they haven't said they are going to close the hospitals, as Mr. Nelsen has frequently pointed out in the course of these hearings. If they did, however, there would't be much anybody could do, really?

Mr. DEMBLING. There is not much the Comptroller General could do under those circumstances, that is correct.

Mr. ROGERS. Couldn't you, if the gentleman would permit——

Mr. KYROS. Certainly.

Mr. ROGERS (continuing). Couldn't you say there would be no funds used for the expenditure of closing up?

Mr. DEMBLING. It gets into a worrisome problem, because it goes back to the question that Mr. Nelsen raised: when do you start disallowing the funds to be expended. You certainly couldn't do it after the closure of one hospital, because you still had a system, so that it would have to be at some point when there is a determination that you have destroyed the Public Health Hospital System that you could move in and say, we are going to disallow the expenditure of funds to close all of the hospitals. Certainly you could conjecture that after the closing of seven, and when they started closing the eighth that you could start disallowing expenditures as a violation of the law. But it would be a difficult problem.

Mr. KYROS. As I understand, you are going to provide the chairman, upon his request, with the citation which establishes the Comptroller General in the normal course of business as the legal authority for the expenditure of funds? [See p. 202, this hearing.]

Mr. DEMBLING. Yes, sir.

Mr. KYROS. But not necessarily acts, like saying, "we are going to close"?

Mr. DEMBLING. Correct.

Mr. KYROS. You are not necessarily the authority for that?

Mr. DEMBLING. No—maybe I misunderstood your question.

Mr. KYROS. You say you are the authority for providing judgment and conclusions at law where the sums can be disbursed and set for certain purposes or not?

Mr. DEMBLING. That is correct.

Mr. KYROS. I am not talking in terms of funds. Suppose, for the purposes of discussion, that it didn't cost a penny to close a hospital and

that you discharged everybody at once and sent them home. Who, then, makes the judgment? Do you have a conclusion that would prevail over HEW?

Mr. DEMBLING. We would not have authority to take any action in that manner.

Mr. KYROS. Is there a citation for that statement you just made?

Mr. DEMBLING. I think that you could read it from the standpoint of the authority of the Comptroller General to disallow funds or the expenditure of funds, so that the converse would certainly be true.

Mr. KYROS. Let me ask you one more question, Counselor.

The other day, the attorney from HEW actually questioned, when we said the Comptroller General rendered the decision, whether that was an attorney rendering a decision. Are you aware of the statement that he made on record?

Mr. DEMBLING. I am aware of the general statement.

Mr. KYROS. Well, you are all attorneys over there who are rendering these judgments?

Mr. DEMBLING. Yes, sir.

Mr. KYROS. Did you read their brief in support of their power to alter and perhaps even discontinue the hospitals?

Mr. DEMBLING. We considered the HEW legal memorandum when we rendered our opinion in response to the chairman of the Merchant Marine and Fisheries Committee.

Mr. KYROS. Now that you have read their brief and perhaps been enlightened, are you going to change the judgment rendered in these two documents given here today?

Mr. DEMBLING. No, sir.

Mr. KYROS. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROGERS. I think we would like your official opinion on contracting services.

Mr. DEMBLING. All right, sir.

(The following information was received for the record:)

OPINION OF OFFICE OF COMPTROLLER GENERAL ON AUTHORITY OF HEW TO ENTER INTO CONTRACTS WITH PUBLIC OR PRIVATE HOSPITALS TO SUPPLY PHS MEDICAL CARE SERVICES

Regarding the question of whether HEW can use its authority under section 322, subsections (d) and (e), to enter into contractual arrangements with other public or private hospitals for the care and treatment of all PHS beneficiaries, we do not think these provisions afford a statutory basis for the contracting out of all such PHS medical care services.

As we stated in our opinion of February 23, 1971, the 1944 Public Health Service Act requires the maintenance of a working PHS hospital system. Since the contracting out of all such PHS medical care services would of necessity result in the elimination of the existing PHS hospital system, such action would, in our opinion, run contrary to the intent of the Congress as expressed in the act that such a system be maintained. In other words, we view the contracting authority as supplementing the requirement to maintain a hospital system.

Mr. ROGERS. Any other comment you would like to make?

Mr. MOORE. In response to your previous question, Mr. Chairman, I have the citation on the law here which states that our settlements of accounts are final and binding upon the executive branch. The citation is 31 U.S.C. 74.

Mr. ROGERS. So it would be binding?

Mr. MOORE. Yes, if we disallow any expenditure in the settlement of accounts it would be final and binding on the executive branch.

Mr. ROGERS. Of course, what I am concerned with is that this whole situation has developed without coming into Congress and asking for a change in the intent of Congress. I think we have been through this before. It is very definite, the intention of Congress, as you stated in your statement that Public Health hospitals be maintained, a system. Just to have no funds in the budget all of a sudden, to cut this off, certainly is contrary to the law and contrary to the intent of Congress. Here we are going out trying to get people to obey the law and we are going to have a problem evidently in trying to get a governmental department to obey the law along with the intent of Congress. I don't mean—this is just this administration.

We had it in 1965 and if governmental officials can't obey the law, I don't know what they expect people who are not involved in government should do. It doesn't set a very good example for one department of government not to carry out the intent of the Congress as stated specifically in the law.

I think your opinions have been most helpful and I think you are correct.

Mr. DEMBLING. Thank you.

Mr. ROGERS. Thank you for being here.

Mr. DEMBLING. Thank you very much.

Mr. ROGERS. Our next witness is—time is really running out fast, and we are sorry and apologize—Col. D. George Paston, Disabled Officers Association, who, as we know, have done great work and great research in this situation, and we appreciate this.

Without objection, your statement and any information you have that is presented to us will be made a part of the record.

If you could highlight the points you would like to make for us——

STATEMENT OF COL. D. GEORGE PASTON, AUS (RETIRED), LEGISLATIVE CHAIRMAN, DISABLED OFFICERS ASSOCIATION; ACCOMPANIED BY MAJ. WALTER J. REILLY, U.S. MARINE CORPS (RETIRED), CHIEF OF STAFF

Colonel PASTON. Thank you, Mr. Chairman.

I have already been identified as being the national legislative chairman of the Disabled Officers Association which was established 52 years ago by seriously wounded war veterans at the Walter Reed Hospital.

Our national commander, Capt. Robert W. Smith, who was awarded the Distinguished Service Cross and other awards and so forth, is in Ohio. He sends his best regards and thanks the committee for enabling us to present his views and the results of our investigation.

I am accompanied by Maj. Walter J. Reilly, U.S. Marine Corps, who had been a prisoner of war in the hands of the Japanese in World War II.

Mr. ROGERS. Major Reilly, we welcome you to the committee.

Major REILLY. Thank you, sir.

Colonel PASTON. I find it unusual to argue in favor of the resolutions to continue the operation of the PHS facilities, because I am unaware of any meritorious opposing reasons.

Our factual documented research and investigation resulted in conclusive reasons for the continuation of these facilities and their ability to care for additional beneficiaries in their communities.

These facts and recommendations were reported by us to the President in letters dated January 28, February 1, 11, and 22. We furnished your committee with copies of these letters, and I wouldn't burden the committee with reading them now, and ask that they be made a part of the record following my remarks.

Mr. ROGERS. Without objection, so ordered.

Colonel PASTON. When word leaked out that the administration had decided ex parte to close the facilities, Congressmen, military retirees, and other beneficiaries became alarmed and many Senators and Representatives came to their rescue by overtures to the administration and our concurrent resolutions. Then, for the first time, the administration decided to conduct reviews and consult with appropriate committees of Congress and of representatives of beneficiary groups, employer organizations, and so forth. I hand you herewith our exhibit A, which is a letter from the White House where they indicate that they are first going to conduct the investigation. They will not close the facilities until after they have consulted with appropriate Members of Congress, as well as these organizations and beneficiaries.

Various statements will be coming forth, I think, with resolutions to the same effect. We have one here which we submit to your committee, marked "exhibit 2," which was introduced in the letters in the State of New York.

Congressman Murphy today spoke about Staten Island Hospital. I agree with what he said. I think your committee should be informed. I don't think it has been, that the Staten Island Hospital, while it was started many years ago, was modernized at a cost to the Government of $26.9 million. So there we have a very large facility for which the Government has spent a lot of money and is already modernized. It has 17 buildings. It is on 23 or 24 acres, and it supervises all the clinics that Congressman Murphy mentioned. Our letters to the President point out all these facts to you.

Another thing that this committee was very much interested in was the fact that these hospitals were not fully utilized. There is something that has been overlooked. I was under the impression, as many people are I think, that we like to see a hospital 100 percent utilized. Here is what the experts say about that, and it is on page 4 of my statement.

A book entitled, "Hospital Organization and Management" by Malcolm T. MacFachern, MD:

> **There seems to be uniform agreement that 75 to 80 percent occupancy is the top limit for safe and efficient care of the patient.**

and we have Galveston telling us they are 90 percent occupied and Staten Island about 66 percent, I think, and others 80 percent and so on. We are getting good utilization out of these hospitals. In any event, I agree with Mr. Nelsen that if we find any possibility of expanding them for use by other beneficiaries in the community, let's do it, but I don't agree with Dr. Egeberg's recommendation that it should be turned over, that is the control of these facilities should be turned over to local communities, because if we do we will get into the CHAMPUS thing and I needn't repeat here what I have in my written

statement to show the terrible things that have happened in CHAMPUS that could happen here.

I think we ought to maintain Federal control. U.S. Public Service hospitals should continue, expand them and take in additional members of the community, and I believe that ought to satisfy everybody.

May I point out one more thing, if I may?

When we talk about contracting with non-Federal institutions, they are just not available and won't be satisfactory. The chairman knows that down in Palm Beach you have the Good Samaritan Hospital—and in West Palm Beach you have the John F. Kennedy Hospital, in spite of which they are now building a new hospital at Lake Worth right near there. In other words, civilian committees don't have enough hospital facilities for themselves and cannot care for PHS beneficiaries.

We can't, therefore, take our Federal beneficiaries and unload them on the civilians. They just won't give us the proper medical care and the cost is terrible. We spend in Staten Island, some odd $60 a day for patients. The cost in civilian hospitals, as the Surgeon General of the Army pointed out, when he conducted an investigation several years ago, was $76.35 a day. We all know that today the civilian hospitals charge $100 a day or more, and that doesn't include medicines and so on; whereas these costs we point out in U.S. PHS hospitals include the drugs and doctors and so forth.

(Colonel Paston's prepared statement and attachments follow:)

STATEMENT OF COL. D. GEORGE PASTON, AUS-RET., NATIONAL LEGISLATIVE CHAIRMAN, DISABLED OFFICERS ASSOCIATION

My name is D. George Paston, Colonel, AUS-Ret. I am the National Legislative Chairman of the Disabled Officers Association, a nonprofit organization, organized 52 years ago in Walter Reed Hospital by severely wounded and maimed officers of WW 1. Our membership is limited to officers of the armed services who are retired for or with permanent disabilities sustained in line-of-duty officially determined to prevent continued performance of active-duty. Our National Headquarters is at 1612 K St., NW., Washington, D.C. 20006.

Our National Commander, Captain Robert W. Smith, wounded several times and decorated with the Distinguished Service Cross among other awards for gallantry in action, is now in Ohio. He asked me to convey to you his thanks for giving us this opportunity to present to you the results of our investigation of the USPHS facilities.

I am accompanied by Major Walter J. Reilly, U.S. Marine Corps., Ret., our Chief of Staff, who had been a prisoner of war in the hands of the Japanese in WW 2.

I find it unusual to argue in favor of the Resolutions to continue the operation of the USPHS facilities because I am unaware of any meritorious opposing reasons.

Our factual and documented research and investigation resulted in conclusive reasons for the continuation of the USPHS Hospitals and Clinics and their ability to care for additional beneficiaries in their communities.

These facts and recommendations were reported by us to the President in letters dated January 28, February 1, 11, and 22.

Copies of these letters were submitted to your committee in view of which I believe it is unnecessary for me to burden you with my reading their contents to you at this time.

I ask that they be entered in the record with the same force and effect as if I read their contents to you. [See pp. 210–302.]

When word leaked out that the Administration had decided ex-parte to close these facilities, Congressmen, military retirees and other beneficiaries, became alarmed. Many Senators and Representatives came to our rescue by overtures to the Administration and Concurrent Resolutions. Then, for the first time, the Administration decided to conduct reviews and to consult with appropriate committees of Congress and with representatives of beneficiary groups, emplo-

organizations, and community agencies before a final decision is made on the future of the PHS Hospitals and Clinics. I hand you herewith, marked *Exhibit A*, a letter to that effect I received from the White House, signed by Noble M. Melencamp, Staff Assistant to the President. [See p. 208.]

In 1801, Thomas Jefferson said:

> "The will of the people is the only legitimate foundation of any government, and to protect its free expression should be our first object."

In addition to Congress, we may expect to receive Resolutions by State legislatures calling upon the President and the Congress to continue the operation of the USPHS Hospitals and Clinics in their respective States.

I hand you herewith, marked *Exhibit B*, Resolution No. 55, introduced in the New York Senate by Hon. Paul P. E. Bookson. It implores the President and the Congress to continue the USPHS Hospital in Staten Island, and the USPHS Clinics in New York City and in Buffalo, all in the State of New York. [See p. 208.]

The Staten Island Hospital, in one year, had 142,805 outpatient visitors Except for open-heart surgery, it provides complete medical and surgical care. It was modernized at a cost of $26.9 million. It has 17 buildings and 24.1 land acres. It supervises the following USPHS Clinics with the annual number of outpatient visitors indicated:

New York City	122,216
Buffalo	9,337
Charlotte Amalie	377
Chicago	53,650
Cincinnati	15,973
Cleveland	23,812
Detroit	35,328
Philadelphia	32,586
San Juan	21,532
Total	457,616

Our letters to the President, which you have, contain the details concerning the USPHS facilities in other States.

I overlooked pointing out to you the cost of operating the USPHS facilities is far less than contractual costs in non-Federal institutions. According to a recently released study by the Army Surgeon General's Office in Washington, costs averaged $76.35 per patient per day *in 1969* for the 211 large civilian community hospitals studied. Most of us know that civilian hospitals charge much more than that amount, some charging more than $100 today.

To transfer the USPHS facilities from Federal control to community contractual control would sky-rocket the costs and destroy the President's plan to slow the alarming rise in the costs of medical care—his recent state of the Union message.

As only one example, I point out to you that at the Staten Island USPHS Hospital costs averaged only $60.46 per patient day. In Galveston it was only $54.69. In New Orleans it was only $47.53. In Boston it was only $60. Since it is indisputable that it costs the government far less to operate the USPHS Hospitals than to contract the care of their beneficiaries in non-Federal institutions, we can control the alarming rise in the costs of medical care only by continuing Federal operation of the USPHS facilities. And this would be the way to "Insure that no American family will be prevented from obtaining basic medical care by inability to pay," which is another aim expressed by the President in his State of the Union Message.

The overcrowded non-Federal institutions will not admit a patient in less than three weeks after application. USPHS will admit them almost immediately. This is a very important factor when we talk about medical care.

Use of Non-Federal contract resources would be under a program similar to CHAMPUS. Initially, the Champus program paid doctors according to what was known as "negotiated fee schedules-fixed rates," periodically negotiated and agreed upon by CHAMPUS and the medical societies of the various States. From January 1967 through May 1968, CHAMPUS phased in "the reasonable fee concept" based on the usual and customary fee charged by a doctor as compared to the prevailing fee charged by physicians in his particular geographic area. In this system, the CHAMPUS program was following the lead of the social secu-

rity program. Payments by CHAMPUS for surgical procedures rose from 5% in North Dakota to 53% in New Jersey. The median increase was 24% and the additional upward trend followed because the level of physicians' fees has been on the rise appreciably since then. One doctor in San Diego, California, received $176,000 in one year—1968. As the result of an investigation, the doctor refunded $11,121.75 of the amount he received. Of those physicians and clinics paid over $20,000 by CHAMPUS during fiscal year 1968, 34 physicians and 2 clinics were paid between $20,000 and $24,999; 45 physicians and 7 clinics were paid between $25,000 and $49,999; 6 physicians and 2 clinics were paid between $50,000 and $74,999; 1 physician and 1 clinic were paid between $75,000 and $99,999; and 1 physician, the one above-mentioned, was paid $176,000. We all know that USPHS physicians are paid far less.

In the CHAMPUS program, the Department of Defense, in cooperation with the health insurance industry, developed a program offered by the Blue Cross-Blue Shield. Subsequently, the Blue Cross-Blue Shield withdrew from the program thus ending all maternity care under the program.

Dr. Egeberg, Asst. Secy. for Health & Scientific Affairs, Dept. of Health, Education & Welfare, testified that they are now aiming (1) to convert the USPHS facilities to local control and use, on contract care for services to USPHS beneficiaries; and (2) To provide care for the beneficiaries through contracts with public and private hospitals with little reliance on the converted PHS facilities or VA hospitals. He said that 40% of the beds would be available for the primary beneficiaries and over half of the beds for community patients. He overlooked the fact that "There seems to be uniform agreement that 75 to 80% occupancy is the top limit for safe and efficient care of the patient" (Hospital Organization & Management, by Malcolm T. MacEachern, M.D., 1962 Physicians Record Company, Berwyn, Illinois, page 202).

He also said that only 40% of the available beds would be for "primary" beneficiaries and community patients would "make up over half of the patient load." He forgot the other legal beneficiaries, called "secondary beneficiaries," such as Bureau of Employees Compensation cases, members of the uniformed services, active and retired, and their dependents.

This can be demonstrated by the Staten Island PHS Hospital statistics for FY 1970, where 7809 admissions consisted of: 3318 American Seamen, 376 BEC, 1019 Coast Guard, 26 PHS Comm. Officers, 858 Special Study, 373 Dept. of Defense, 313 Other[1], 880 DOD Dependents, 417 CG, ESSA and PHSA Dep., 93 Foreign seamen, 136 VA.

I can burden you, if you wish, with the details or statistics of outpatient visits for FY 1970, which show that 143,784 visits consisted of approximately 10% community patients, the great majority being "primary" and "secondary" beneficiaries.

Note: Primary beneficiaries are: American Seamen, Coast Guard personnel, PHS, and ESSA.

In view of these facts, to give control to local communities would be asking the tail to wag the dog. Where welfare money was poured into local control, millions of dollars were stolen, and Cities and States are asking the Federal government to control the welfare system.

In his recent State of the Union Message, the President said: "America has been the wealthiest nation in the world. Now it is is time we became the healthiest nation in the world."

To accomplish that aim, we are fortunate that we have the USPHS Hospitals and Clinics with their staffs, buildings, and equipment, in operation for legally designated beneficiaries to which the law can add community patients.

One of the best things the President and the Congress can do for our people and the nation is: (a) Continue the operation of the USPHS facilities, under Federal control; (b) Add community patients as beneficiaries in these facilities.

Many Congressmen, alarmed by the announcement that these facilities would be closed, sprang to the rescue by overtures to the Administration and by Resolutions. Each Congressman who introduced, cosponsored, and will support these Resolutions and the President, if he follows this recommendation, will have earned the gratitude of our nation's people who will benefit by prevention and

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[1] Note: "Other" includes other secondary beneficiaries and "emergency" cases. Only 12 to 14% are "community patients" (study and emergency cases). The great majority are legal, primary and secondary, beneficiaries.

cure of disease which the USPHS facilities are organized to do and are doing to attain the goal of making America the healthiest nation in the world.

I shall be glad to try to answer any questions.

EXHIBIT A

THE WHITE HOUSE,
Washington, February 27, 1971.

Col. D. GEORGE PASTON,
175 Adams Street,
Brooklyn, N.Y.

DEAR COLONEL PASTON: The President has asked me to thank you for your letters of January 28, February 1, and February 11 concerning the study of the hospital and clinic system of the Public Health Service. The information you have sent is much appreciated. I can well understand your special concern for disabled officers and their dependents who are served by Public Health Service facilities.

The Administration, too, is concerned that the best possible resolution of this situation should be reached. The Department of Health, Education, and Welfare is conducting reviews in each of the communities where there are Public Health Service hospitals in order to determine what provisions can be made for the care of PHS beneficiaries and the possible use of these facilities by communities. The Administration has every intention of consulting fully with the appropriate committees of the Congress and with representatives of beneficiary groups, employee organizations, and community agencies before a final decision is made on the future of the Public Health Service hospitals and clinics.

You may be sure that your views have been brought to the attention of the appropriate authorities who are studying the situation.

With best wishes,

Sincerely,

NOBLE M. MELENCAMP,
Staff Assistant to the President.

EXHIBIT B

Concurrent resolution expressing the sense of the Legislature of the State of New York with respect to the continued operation and expansion of the United States Public Health Service Hospital at Staten Island, and the United States Public Health Service Clinics in New York City and in Buffalo, New York.

Whereas, The United States Public Health Service Hospital at Staten Island provides medical and surgical treatment, medical care and outpatient medical treatment, pursuant to federal law, to thousands of American seamen, federal employees, retired military personnel, their dependents, and many others; and

Whereas, The United States Public Health Service Clinics in New York City and Buffalo provide outpatient medical treatment pursuant to federal law, to thousands of beneficiaries; and

Whereas, These facilities have earned the well-earned appreciation and approbation of their patients, some of whose lives have been saved by their surgical and medical care and the health of thousands of others have been improved; and

Whereas, Said hospital is affiliated with the Columbia-Presbyterian Hospital, College of Physicians and Surgeons, the Albert Einstein Medical College, and other top notch medical institutions, for medical training and research; and

Whereas, The cost to the government of inpatients averages less than sixty dollars per patient per day, and the outpatients less than fourteen dollars per patient per day; and

Whereas, The Secretary of Health, Education and Welfare is considering the closing of said hospital and clinics allegedly to save the cost of their operation and to contract with the Veterans Administration or non-federal institutions for the care of United States Public Health Service patients; and

Whereas, The Veterans Administration hospitals, in caring for their own statutory patients, are unable to accommodate United States Public Health Service patients except on a space available basis, if at all; and

Whereas, Non-federal contract resources accessible to United States Public Health Service patients, due to their own patient load, are unavailable to accommodate and provide the United States Public Health Service patients with the immediate care they require and, even if they were available, such contract

expenses would far exceed the cost of continuing the operation of the United States Public Health Service facilities since a study by the Army Surgeon General's Office revealed that costs averaged $76.35 per patient per day in 1969 for the two hundred eleven large civilian community hospitals studied, the the cost is alarmingly increasing; now, therefore, be it

Resolved (if the Assembly concur), That it is the sense of the Legislature of the State of New York that the United States Public Health Service Hospital in Staten Island and the United States Public Health Service Outpatient Clinics in New York City and in Buffalo, New York, should remain open, continue to care for their statutory beneficiaries and expand, if possible and practicable, to also care for additional beneficiaries, as a foundation to effectuate the President's plan, announced in his State of the Union Message, to insure that no American family will be prevented from obtaining basic medical care by reason of inability to pay; slow the alarming rise in the costs of medical care; and to make America the healthiest nation in the world; and be it further

Resolved (if the Assembly concur), That a copy of this resolution be transmitted to the President of the United States, the Secretary of the Senate of the United States, the Clerk of the House of Representatives of the United States and to each member of Congress of the United States duly elected from the State of New York and that the latter be urged to devote themselves to the task of accomplishing the purpose of this resolution.

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

Organized in 1919

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MAJOR MORRIS E. BROWN
NATIONAL VICE-COMMANDER
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MAJOR JOSEPH A. CARR, JR.
PAST NATIONAL COMMANDER
CAPT. PAUL F. SHAUGHNESSY, PNC
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MAJOR ROBERT W. GARDNER
NATIONAL CHAPLAIN
CAPT. JOSEPH L. ROTHFEDER
NATIONAL SURGEON
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LT. COL. SYDNEY G. OSBORNE, FLA.

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MAJOR FRANK E. BACHELDER, CALIF.
CAPT. R. L. EVANS, ARIZ.

CHAIRMAN
NATL. LEGISLATIVE COMMITTEE
COL. D. GEORGE PASTON
170 ADAMS STREET
BROOKLYN, N.Y. 11201

January 28, 1971

President Richard M. Nixon,
The White House,
Washington, D. C.

Dear Mr President,

Opposition to the closing of USPHS Hospitals & Clinics.

We urge you to continue and expand their operation because:

(a) they are rendering inpatient and outpatient medical services of great value to so many beneficiaries, seamen, government employees, military retirees, and other members of the public;

(b) if closed, contractual care of these patients at other facilities will cost the government far more than the continued normal operation and expansion of the well-organized PHS facilities;

(c) if closed, these patients will be exposed to less care, if any, at less convenient medical facilities where the average waiting time for patient admission is six weeks; and

(d) their continued operation and expansion can be the foundation upon which the laudable medical program announced in your January 22, 1971 State of the Union Message may be based.

PRESIDENT NIXON'S STATE OF THE UNION MEDICAL PROGRAM.

(a) Insure that no American family will be prevented from obtaining basic medical care by inability to pay;

(b) Slow the alarming rise in the costs of medical care;

(c) Appropriation of an extra $100 million to launch an intensive campaign to find a cure for cancer; and

(d) America has been the wealthiest nation in the world. Now it is time we became the healthiest nation in the world.

CLOSING THE PHS HOSPITALS & CLINICS WOULD DEFEAT PRESIDENT NIXON'S MEDICAL PROGRAM AND WOULD BE A TOO EXPENSIVE FOLLY.

Since we need hospitals and clinics, it would be irrational and insane for anyone to propose burning or closing the PHS hospitals and clinics.

It would be difficult or even impossible to contract for and actually receive medical care comparable to the USPHS. It would cost the government billions of dollars to build new hospitals and clinics. This is unnecessary since we have the buildings, equipment, physicians, and employees, now operating the PHS facilities.

CANCER, THERAPY, RESEARCH.

At Baltimore, Maryland, the PHS hospital has 238 beds. 35 of these beds are National Cancer Institute beds, a considerable part of the Institute's 120 bed total.

At Seattle, Washington, the PHS hospital is affiliated with the Division of Oncology of the University of Washington. The Division uses one-half of the 7th and 10th floors of the hospital, employs 56 persons, including 14 physicians who work at the USPHS hospital. The Division has funds, provided by the National Cancer Institute, with which it carries on:

Adult Leukemia Research Center;

Separation of blood by continuous flow centrifuge;

An oncology training program;

Immunologic aspects of autochthonous tumor regression;

Normal and abnormal bone marrow metabolism; and

Investigation of the role of Isogeneic and allogeneic marrow in the therapy of cancer.

The Division has funds, provided by the National Institute of Allergy and Infectious Diseases, for Evaluation of typing techniques in clinical hemotransplantation, and for irradiation and marrow transplantation in large animals.

It has funds, provided by the National Heart & Lung Institute, for prepartion of Platelet concentrates.

The USPHS pays one physician $21,300. The American Cancer Society pays one Fellow a $4,800 stipend. The Leukemia Society has a $10,000 Special Fellowship. The State of Washington provides $27,000. Patients donated $5,000. Total expended in one year is about $1 million.

At Miami, Florida, the USPHS Clinic also treats an increasingly large number of Dade County patients afflicted with Hanson's Disease (Leprosy).

The San Francisco PHS Hospital averages between 260 and 300 patients a day and receives approximately 116,000 outpatient visits a year. The leprosy service has at present 314 leprosy patients registered and under treatment on an ambulatory basis except for brief periods of hospitalization. The Inpatient Leprosy Service averages 5 patients. Any patient in the Western United States suffering from this disease may assisted at the Leprosy Clinic held Tuesdays and Thursdays. In addition, nearly 100 contacts of active leprosy patients are under the continued surveillance of the Clinic. Of 149 registered male patients between the ages of 14 and 65 with leprosy, 110 are actively engaged in their usual occupations or attending school. Of 97 female patients between those ages, 59 are useful homemakers, employed, or are students. The Laboratory is funded by a $75,000 annual N.I.H. grant with a staff of 2 physicians, 2 technicians, 1 animal caretaker, and 1 secretary.

The hospital also operates a psychiatry clinic, a coronary care unit, an intensive care unit, an alcoholic and drug detoxification unit, a yellow fever immunization clinic, a metabolic unit, a cardiovascular project, a laboratory for performing sophisticated analyses of the lipid contents of blood in high volume and with rigid quality controls. During 1970, over 26,000 lipid analyses were performed in studies involving phenotyping project, the hyperlipidemia diet intervention program, the pediatric screening program. It also operates a hypertension clinic, a renal clinic, a virology laboratory unit, a department of nuclear medicine which handled 955 patients in the last six months of 1970.

Its Cancer Clinic and Tumor Registry, accredited by the American College of Surgeons, has been in operation over 15 years. More than 2000 patients are seen annually. The Clinic follows an average of 468 patients with major malignancies, exclusive of skin cancers, per year. Patients are not only Federal beneficiaries but also Special Study patients from the San Francisco community. To continue describing the work of this hospital would fill a book. We assume that you have been furnished a copy of the document entitled "Special Services Provided By The PHS Hospital, San Francisco, California," rendering it unnecessary to repeat its contents here.

THE ASCRIBED REASONS FOR THE CLOSINGS ARE THE BEST REASONS FOR THE CONTINUANCE OF THE PHS HOSPITALS AND CLINICS.

HEW Secretary Elliot Richardson said that the PHS facilities are underutilized and outmoded. He recommends their closing and to arrange with the VA to care for the patients on a space available basis with no modification in present VA beneficiary priorities; that, in those locations or situations where the VA cannot serve the patients' needs, to utilize non-Federal contract resources more accessible to the beneficiaries.

"Space availability basis" means that if space is not available, as is usually the case, the patient cannot be accepted.

An adequate number of non-Federal contract resources to care for the present PHS beneficiaries are not available. Even if they were available, they would be too expensive in view of the alarming rise in the costs of medical care.

The assumption that PHS facilities are underutilized is THE BEST REASON for continuing and expanding their operation to include additional beneficiaries. Patients would thereby be more easily accomodated than in VA hospitals on a space available basis or in fully utilized and overcrowded non-Federal contractual resources.

If any PHS facilities are not modern, they can be modernized at little expense. Beekman-Downtown Hospital in New York City was not closed because it was outmoded. It was modernized and serves a most useful purpose. The same is true of many of the best non-Federal hospitals. And, it is not true that the PHS facilities are not modern. We cannot conceive of a more modern facility than the PHS Clinic at 245 West Houston St., New York City, the largest outpatient clinic of the PHS in size and patients. During the fiscal year, from July 1, 1969 to June 30, 1970, this clinic handled 115,000 outpatients. In addition to medical and dental treatment, its yellow fever center administered 7200 immunizations, and the clinic conducted 26,000 immigration examinations and 5,000 physical examinations. There are 10 physicians in the General Medical Clinic, 9 Dentists, 8 Physical Therapists, 2 Pharmacists, an X-ray Department, a Laboratory Department, a Nursing, and Medical Records Department. The 115,000 outpatient visits, at a cost to the government of $1,226,829, amounts to $10.66 per visit, which compares very favorably with the cost in non-Federal hospitals.

We also cite the very modern Tampa, Florida, PHS facility, as another example (see Exhibit 1, hereto attached).

Regarding accessibility of PHS facilities to beneficiaries, we cite the Portland, Maine, PHS hospital, as an example (see Exhibit 2, hereto attached).

It would be fair to summarize the reasons advanced for the closings, by referring to President Nixon's address to the United States Junior Chamber of Commerce in St Louis, Missouri, June 25, 1970, in which he said:

> "This is like a doctor telling you when you have a sore finger that the cure is to cut off your arm."

PHS FACILITIES RENDER UNIQUE MEDICAL SERVICES, UNAVAILABLE ELSEWHERE, AT A LOW COST TO THE GOVERNMENT.

The USPHS Clinic in Honolulu is a modern new clinic, only five years old.

Its staff of 31 employees and two medical consultants on the capital island of Oahu and four clinics and physicians on the other Hawaiin Islands-two clinics in Hawaii, one in Mauri and one in Kauai, serve:

American seamen,
* Nat'l Oceanic & Atmospheric Administrative officers.
* Army, Navy, Air Force and Marine Corps uniformed service personnel,
* Dependents of uniformed services personnel,
* Coast Guardsmen,
Bureau of Employees Compensation Recipients.

(* Active duty and retired personnel.)

Medical assistance is furnished thru the Coast Guard to all ships at sea, both American and foreign, at all times, DAY AND NIGHT and, occasionally, to isolated islands throughout the Pacific.

For the past several years, it had 33,000 patient visits. Its FY 1970 budget of $455,300, averaged the cost per patient of $14 or less. If it were closed, contractual costs per patient would be far more. This would also be true as to uniformed services' dependents who would be referred to the Champus Program.

An American Seaman is usually a transient docking about a day to three days. The cost of contracting out the treatment of such walk-in patients (no appointments) and filling the necessary medical and insurance forms would be prohibitively expensive. And we cannot contract medical assistance to all ships at sea or to isolated islands throughout the Pacific.

Retired personnel of the armed services and their dependents may avail themselves of the medical facilities at the U.S. Army Tripler General Hospital, Pearl Harbor Dispensary, Hickam Air Force Base Dispensary, and Kaneohe Marine Base Dispensary. This group, for reasons of accessibility or other causes, apparently prefers the USPHS facility, evidenced by 1,300 patient visits per year.

Information from a reliable source indicates that (a) it would be impossible for the other medical facilities and the VA to accomodate the PHS's average patient load of 33,000 visits, and (b) it would be much costlier than PHS facility operation.

The unique medical services required by seamen are ably described in the Buffalo, New York, PHS facility report (exhibit 3, hereto attached) and in the Cleveland, Ohio, PHS facility report (exhibit 4, hereto attached).

PHS HOSPITAL, STATEN ISLAND, N.Y.

This hospital was MODERNIZED at a cost of $26.9 million.

Except for open heart surgery, it provides complete medical and surgical care.

ADPL: 420. 268 are PHS beneficiaries. 152 are others.

OUTPATIENT VISITS: 142,805, consisting of 72,360 PHS beneficiaries and 70,446 others.

There are 17 buildings on 24.1 acres. FY Budget: $13,675,067. Per Diem cost:$60.46. Outpatient visit cost: $14.82.

Total Personnel: 1060. 162 physicians, 16 dentists, 14 pharmacists, and 43 others, amount to 235. 227 nursing, 126 dietary, 59 housekeeping, 53 laboratory, 38 radiology, 74 engineering and maintenance, 41 on medical records, 207 others, amount to 825 Civil Service personnel.

The above figures include 30 medical interns, 68 medical residents, 24 others, amounting to 122.

This hospital is also responsible for PHS medical care activities in New York, New Jersey, parts of Connecticut, Pennsylvania, Ohio, Michigan, Illinois, the Virgin Islands, and Puerto Rico.

It operates as a medical center with direct responsibility for these outpatient clinics:

	Annual Visits	
Buffalo, N.Y.	9,337	
Charlotte Amalie, V.I.	377	
Chicago, Ill	53,650	
Cincinatti, Ohio	15,973	
Cleveland, Ohio	23,812	
Detroit, Mich	35,328	
New York, N.Y.	122,216	
Philadelphia, Pa.	32,586	
San Juan, P.R.	21,532	314,811

Adding these 314,811 visits to the Staten Island Hospital's 142,805 outpatient visits, totals 457,616 outpatient visits.

It provides isolation facilities for quarantinable disease for the Foreign Quarantine Division, medical evaluations for the U.S. Immigration & Naturalization Service, hospitalization of complex medical care cases for the Bureau of Prisons, medical evaluation and treatment for Department of Labor, Bureau of Employees Compensation referrals, operation of an East Coast Leprosy Center. In 1968, it performed 7,077 operations. It has training affiliation agreements with Columbia College of Physicians & Surgeons, the Albert Einstein Medical College, the New Jersey College of Medicine, Columbia Presbyterian hospital, the University of Pennsylvania Division of Physical Therapy, the New York Medical College, and many others It has a cardiopulmonary laboratory, and a renal-electrotype laboratory, renal dialysis, artificial lung, cobalt therapy, diagnostic isotope screening.

According to a recently released study by the Army Surgeon General's Office in Washington, costs averaged $76.35 per patient day in 1969 for the 211 large civilian community hospitals studied. That cost is alarmingly increasing.

To avoid duplicate reading of the details of the many medical services rendered by this hospital, reference is made to the attached document entitled "U.S.Public Health Service Hospital, Staten Island, Staten Island, New York. Briefing Information," marked Exhibit 12.

The undersigned, now 72 years of age, resided in the New York area all his life (except during World Wars I and II when he served in the Army). From time to time, he spoke to many individuals who were treated medically and surgically in the Staten Island PHS Hospital. Every one of them voluntarily and enthusiastically praised the service he received there.

THIS HOSPITAL IS A READY-MADE FOUNDATION UPON WHICH THE PRESIDENT'S LAUDABLE MEDICAL PROGRAM (January 22, 1971 State of the Union Message) MAY BE BASED.

More detailed statements are included in the following attached Exhibits:

Exhibit 1 TAMPA, Florida,
2 PORTLAND, Maine,
3 BUFFALO, New York,
4 CLEVELAND, Ohio,
5 CHICAGO, Illinois,
6 SAVANNAH, Georgia,
7 ATLANTA, Georgia,
8 MIAMI, Florida,
9 PHILADELPHIA, Penna.,
10 MOBILE, Alabama,
11 NEW ORLEANS, Louisiana,
12 STATEN ISLAND, New York.

Because of their interest in this subject, copies of this communication are being sent to HEW Secretary Elliot Richardson and the Merchant Marine & Fisheries Committee of the House of Representatives.

Sincerely yours,

D. George Paston,
Col., AUS-Ret.,
Legislative Chairman, Disabled Officers Ass'n.

Inclosures: as listed.

EXHIBIT 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

January 22, 1971

Colonel D. G. Paston - Chairman
National Legislative Committee
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Sir:

It was a pleasure to hear from you. All the employees will be pleased that someone cares about the closure of our Hospitals and Clinics.

Far from outmoded, this Clinic in Tampa was completely renovated in 1967-1968 with the most modern and the very latest of medical, dental and scientific equipment. The cost of renovation was in the range of approximately $312,059 which was the approximate cost to the U.S. Public Health Service; the over-all cost was probably in the range of $450,000. Capitalized equipment cost $153,164 which does not include medical books and journals. The Staff moved into this new facility on July 1, 1968. Our Clinic occupies 14,740 cubic feet of floor space on the first floor of the Federal Courthouse and Post Office Building in downtown Tampa.

The physical layout of this Clinic consists of the following facilities:

There are offices for 4 physicians, each physician has a suite of 2 interconnecting examining rooms with the latest Valtronic Units, as well as other modern equipment. All, except one unit, have toilets.

The Nursing Section consists of a Nurses Office, adjoining the Treatment and Procedures Room, Recovery Room, Observation Room and EKG Room, together with a completely equipped Minor Surgery Operating Room. Piped-in oxygen and vacuum systems are available in the Recovery, Surgery, and Treatment and Procedures Rooms. Piped-in compressed air is available in the Treatment and Procedures and Surgery Rooms. There are 2 EKG machines.

We also have a new rear elevator, and a few parking places for patients in the rear, especially for those patients who are not ambulatory. There is also a front elevator on the ground floor which many patients use.

The Dental Clinic has a very modern section which consists of 8 operatories: 4 operative rooms, 1 oral surgery room, 1 dental hygienist room, 1 x-ray room with associated developing room, and 1 prosthetics room; a laboratory, and supply room. The dental equipment which is the most modern including the dental x-ray unit cost a total of $26,903. This does not include the vacuum system which cost approximately $5,000. Piped-in oxygen is available in all operatories and the oral surgery room.

In addition, there is available a very complete and well equipped Physical Therapy Department with a hydrotherapy section and whirlpool baths. The physical therapy area is probably one of the most delightful areas in the Clinic.

The Pharmacy is a completely equipped, ultra modern unit. Equipment includes a Barnstead still, a new Triumph digital table counter, Monarch labeling machine, refrigerator, Al-Sop mixing tank (60 liters), typewriter, and weighing balances. Ample storage space is ideally located in an adjoining room with a special ventilated cabinet for the storage of flammables. Pharmacy cabinetry is more than ample and consists of natural-finish Swartz units. There is also a recently completed consultation booth at the dispensing window. The Pharmacy maintains a complete library of pharmacy literature and there is an adjoining office for literature review and administrative duties.

Clinical Laboratory with the latest automated equipment.

X-ray Department which is equipped with a Phillips Diagnex-50 Diagnostic X-ray Unit and an Eastman Kodak Instamatic Film Developer, X-OMAT, which develops films in 90 seconds.

The Receptionist Area is very spacious and modern consisting of 2 admitting booths and Lobby for the patients to wait. The Receptionist Area contains an Addressograph Machine for processing patient identification cards which identifies patient as to name and file number.

Additionally, there is a Medical Records Section with Diebold Power Files: Medical Records are filed by terminal digit utilizing the patient's Social Security Number. Index to patient's records are also filed in Diebold Power Files.

The Clinic's Administrative Section consists of Administrative Offices, Nyematic Dictating System with dictating stations located in each doctor's office and the radiology reading room; a Medical Library with very complete set of medical books, all quite recent, the cost of these books must be at least $5,000 - additionally, we have had medical journals bound and on the shelves; the Conference Room, well equipped with ample seating capacity for all Clinic members, a slide projector and movie projector with a large screen for medical films; Employees Lounge; and, a Health Unit for Federal Agencies in the area is equipped and awaiting personnel to man it.

The Clinic is staffed by both Commissioned Corps and Civil Service Personnel. The Commissioned Officer complement consist of 4 Medical Officers, including mysclf, 2 Dental Officers, 2 Pharmacists, and a Physical Therapist. The civilian complement totals 16 Civil Service employees of which we have 2 Registered Nurses, 1 Licensed Practical Nurse, 2 Medical Laboratory Technicians, 1 X-ray Technician, 2 Dental Assistants, 1 Secretary, 3 Administrative Clerical Personnel, and 4 Medical Records Personnel.

The patient load for Fiscal Year 1970 was 32,046 patient visits compared to 33,553 patient visits for Fiscal Year 1969, or an average of 124 patient visits daily. Approximately 50% of the patient load are eligible to be seen in Department of Defense facilities.

Thank you for your interest.

Sincerely yours,

Linden E. Johnson, M.D.

LINDEN E. JOHNSON, MD
Medical Director
Medical Officer in Charge

EXHIBIT 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

OUTPATIENT CLINIC
331 VERANDA STREET
PORTLAND, MAINE

January 19, 1971

Col. D. G. Poston
175 Adams Street
Brooklyn, New York

Dear Col. Poston:

The following information is supplied in response to your letter of January 15, 1971, regarding closure of Public Health Service facilities:

The Outpatient Clinic, Portland, Maine, served approximately 20,000 patients last year. The approximate breakdown according to beneficiary class was:

Coast Guard	- 20%
Dependents, Dept. of Defense	- 20%
Coast Guard Dependents	- 18%
American Seamen	- 8%
Department of Defense	- 12%
Other	- 22%
PHS	
Bureau of Employment Compensation	
Federal employees	
Innoculation & Vaccinations	

Stationed at Portland in the Coast Guard are approximately 850 active duty personnel assigned to 3 Coast Guard cutters, 4 smaller ships, Coast Guard Base, Portland, Maine, and outlying installations along the coast of Maine.

Portland, Maine, is also a very popular area for retirement of military personnel, one of the attracting features being the availability of medical care at the Public Health Service Clinic.

The average cost in medical supply per patient is $1.56.

The nearest Veterans Administration Hospital is at Togus, Maine, approximately 130 miles from Portland, Maine. Personal experience has shown a wait of up to a month for elective admission at Togus.

The staff at the clinic consists of:

1 Director-pharmacist
2 Physicians
2 Dentists
2 Nurses
2 Dental technicians
1 laboratory technician
1 clerk-typist
1 clerk-stenographer
2 maintenance men

I hope this information will be useful. If you need more specific information, please contact Mr. Richard Gallant, Director, U. S. Public Health Service Outpatient Clinic, 331 Veranda Street, Portland, Maine. Mr. Gallant is presently on leave.

Sincerely yours,

Edward M. Solomon, M.D.

Edward M. Solomon, M. D.
Chief Medical Officer

EXHIBIT 3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

January 19, 1971

U S PUBLIC HEALTH SERVICE OUTPATIENT CLINIC
BUFFALO, NEW YORK 14203

Col. D. G. Paston
175 Adams Street
Brooklyn, New York 11201

The Merchant Marine and the Coast Guard travel from port to port, to all the seas, all the Great Lakes and all the rivers.

Medical care for transient members entitled to U. S. Government coverage is a special type of service. The medical care to American Seamen and Coast Guardsmen in the 173 years of the USPHS (1798 - 1971) has been and shall be excellent.

Diagnosis and treatment in other than USPHS facilities is not practical in that a long waiting period to see the doctor is involved.

Great Lakes ships are in port 4 to 8 hours. Waiting to be examined by a doctor in a non USPHS facility many times exceeds this period. USPHS doctors understand the special duties of seamen, Coast Guardsmen and Federal employees (beneficiaries of the U. S. Labor Department when injured on the job) and know how to communicate with them and how to determine duty status recommendations for further care.

It is, therefore, strongly recommended that USPHS Hospital-Clinic care be continued and expanded in the best interest of the nation and general welfare.

Very truly yours,

Thomas C. McDonough, M. D.,
Medical Officer in Charge

EXHIBIT 4

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

CHIEF MEDICAL OFFICER
U.S. PHS OUTPATIENT CLINIC
694 U.S. POST OFFICE BUILDING
WEST THIRD AND PROSPECT AVENUE
CLEVELAND, OHIO 44113

20 January 1971

Colonel O. O. Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

In reply to your letter of January 15, 1971, which presented our clinic with the tentative schedule for the closing of the U. S. Public Health Service Hospitals and Clinics, I would like to make known some pertinent facts regarding the Cleveland Outpatient Clinic.

Our clinic here, as other Public Health Service Clinics, takes care of Coast Guard personnel, their dependents, and seamen in the Merchant Marine primarily. In addition, we regularly examine persons eligible for employment compensation and disability retirement for the Post Office and other Government agencies. Almost daily we examine FBI personnel, either for annual physical examinations, or for applications to the FBI Service. We examine retired military personnel in all services, care for the dental health of these patients as well, and recently have been providing regular care for Vista personnel stationed in Cleveland. We also do annual examinations for the Department of Defense in their executive department, and entrance examinations for candidates to the Peace Corps, State Department Foreign Service, Vista, and the Public Health Service itself. Our clinic here in Cleveland is the regional yellow fever center, and weekly we see from fifteen to fifty patients who obtain their yellow fever vaccine here.

Our total annual census, including the dental clinic, was approximately 18,000 visits for the fiscal year 1969. For these patients we provide full medical care, including medications, diagnostic studies, basic clinical pathology, and complete radiographic studies, including gastrointestinal contrast examinations and intravenous pyelograms.

We have readily available to our clinic, and make regular use of consultants in radiography, internal medicine, neurology, otolaryngology, ophthalmology, gynecology, dermatology, psychiatry, and allergy.

Our annual budget for 1969 was less than $194,000, approximately less than $11 a patient visit for what we consider complete care. It is hard for me to imagine physicians elsewhere in this community providing such complete diagnostic and therapeutic services for anywhere near that price. The most distressing fact related to the possible closing of this clinic is the criticism that we are outmoded, inefficient, and under utilized. Although the clinic walls could use a painting, we are NOT outmoded and not inefficient. Certainly we are not seeing

the number of patients we have seen in prior years, but it is my feeling this reflects, in part, the availability of other federally funded health care services i.e. Medicare. We are, however, running an active clinic which requires the presence of two full time physicians and one part time physician, three nurses, two dentists, and two dental assistants.

Equally as distressing is the recent publicity given to the Bill HR-19860, signed by President Nixon, which has granted $60,000,000 to the Public Health Service to utilize commissioned officers such as myself in ghetto areas of cities such as Cleveland. Our clinic, although not located in a ghetto area, is located in the heart of metrupolitan Cleveland. We are less than one hundred yards from the hub of all public transportation in Cleveland, making us more readily accessible to all segments of the population than any other clinic facility in this city, and certainly more accessible than the difficult-to-reach Veterans Administration Hospital and Outpatient Clinic, which is postulated to take over care of our patients.

I think Senators Magnuson and Jackson of Washington, D. C. have authored and sponsored a fine piece of legislation. However, replacement of this clinic with physicians sponsored by their bill would be a definite unnecessary expense to the Government. Transferring our patients to the Veterans Administration Hospital for their care and providing Public Health physicians and dentists for ghetto areas here in Cleveland would be an unnecessary duplication of services. We have at least 1,500 square feet of unused floor space immediately available for expansion into offices and examination or treatment rooms within the clinic as it exists today.

I have not practiced medicine at the Cleveland Veterans Administration Hospital, but I have had several opportunities to visit their already-crowded emergency room and outpatient clinic, and I don't believe they can conveniently see the 1,500 or more patients per month we see here in our clinic now. Expansion to handle the needs there could equally be matched by expansion here in our centrally-located clinic at equal, if not less, cost to the Government. It is my feeling that we should continue to care for the patients we are now seeing, and that a modest increase in our facility would most efficiently and most conveniently handle <u>some</u> of the needs of Cleveland's ghetto population. I believe our clinic <u>is</u> needed <u>where</u> it is, and if expanded to handle a larger patient (?ghetto) population, could provide the <u>comprehensive continuing care</u> which is needed in this city and country at this time.

Sincerely yours,

Stephen A. Kollins

Stephen A. Kollins, M. D.
Surgeon - Acting Chief Medical Officer
CLEVELAND USPHS OUTPATIENT CLINIC

EXHIBIT 5

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

1/22/71

Medical Officer in Charge
U.S. Public Health Service Outpatient Clinic
4141 Cleveland Avenue
Chicago, Illinois 60653

Col. D.G. Paston
175 Adams Street
Brooklyn, N.Y. 11201

Dear Col. Paston:

Thank you for your invitation for us to relate facts and statistics relevant to the closings of PHS hospitals and clinics.

This clinic has full facilities of an outpatient clinic including medical and dental officers, nurses and dental assistants and services in pharmacy, x-ray, laboratory and physiotherapy. We have visiting consultants' services in orthopedics, ophthalmology, optometry, radiology, OB-GYN, dermatology and ENT. We have contract facilities for referral of all medical, surgical and psychiatric problems. In addition, we have a cross-service agreement with the Illinois Department of Mental Health for psychiatric and psychological outpatient care provided in our building. We use our own and also contract for ambulance service.

Our clinic provides medical and dental care for many beneficiary groups, the largest being U.S. Army active, retired personnel and their dependents (17,442 patient visits* for FY1970). The only other sources of care for these patients are the U.S. Army Fort Sheridan and Great Lakes Naval Hospital which are approximately 30 miles away. It has been discussed that Fort Sheridan might be closing in the near future. With a large number of Army patients, especially dependents, the closing of our clinic would cause a great hardship for these people.

We offer almost every kind of immunization. We are one of only two facilities in Chicago that give yellow fever immunizations which are provided, free of charge, to the general public; mainly, for those travelling to other countries. In FY1970 we administered 5,000 immunizations, 28% of these for yellow fever.

Federal employees from all Government agencies in Chicago and surrounding areas receive care. The following statistics are for FY1970:

-Employees injured while on duty------ 3,529 patient visits
-Fitness for duty, disability,
* retirement and routine physical
examinations ------ 605 patient visits

*Patient visit - One or more medical or dental services rendered to a patient on any one day.

Alieno applying for permanent visas ars determined medically admissible or inadmissible as citizens of thie country. FY1970, 5,652 of theee petients received physical examinatione at thie facility.

American seamen, who were the first beneficiaries of the U.S. Public Health Service hospital and clinic system, which began in 1798, made 2,713 visits to the clinic in FY1970.

The USPHS serves as the medical arm to the U.S. Coast Guard, as they have no medical or dental personnel among their ranks. In FY1970, 1,722 applicants, active and retired personnel, and dependents were served.

The Illinois Department of Mental Health, mentioned above, provided psychiatric and psychological outpatient care to 2,441 of our patients in FY1970.

We are involved in three programs for which we provide physical examinations and follow-up medical and dental care to socio-economically deprived persons seeking employment. These programs are the Neighborhood Youth Corps, Work Incentive Program, and the Concentrated Employment Program. In FY1970 we had 5,945 visits from these people.

May, 1970 we began the Model Cities Program which is unique to the USPHS. This program provides medical and dental care to residents in the neighborhood. Most of these patients have received in the past little or no care due to socio-economic reasons and the health crisis existing in Chicago. Please note that this program coincides with the Emergency Health Personnel Act recently signed into law by the President. From May,1970 to the present, these patients have made 3,017 visits to our clinic.

We treat other beneficiary groups for which I will not burden you with details. The total patient visits to our clinic in FY1970 were 53,469. Projections for FY1971 indicate approximately 65,000 patient visits.

The clinic has tremendous potential for adding more programs and providing in-service training. In the future we plan to expand services for prevantive medicine. Plans for starting a TB clinic are being discussed with the Chicago Board of Health. We provide on-the-job training for dental hygienists and medical students. We have requested that the city send us applicants who we are willing to train as nurses' aids, dental assistants, clerks, typists, etc.

As to administration's statements of underutilized, inefficient, and outmoded: Any witness could testify that our 70 well-trained, well-qualified personnel are constantly working to maintain that primary goal of good patient care. Underutilization does not apply to this clinic. Inefficiency would be accurately judged by the patient. No letters or voices of complaints have been received from patients. On the contrary, we have received many compliments from patients. Our medical records can offer further evidence of good patient care. Outmoded is a confusing term as in this period

of a declared, national health crisis, all resourses that provide the primary objectivs of good patient care are essential. "Outmoded" facilities can be improved with additional funds. Certainly this expense would be less expensive and more practical than contracting our beneficiaries to other Government agencies already filled to capacity (i.e. VA hospitals).

We deeply appreciate your continued support of our cause. Good luck!

Sincerely yours,

George R Adam, M.D.

George R. Adam, M.D.
Medical Director, USPHS
Medical Officer in Charge

GRA:jeb

EXHIBIT 6

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
SAVANNAH, GEORGIA 31401

January 21, 1971

US PHS
OUTPATIENT CLINIC
SAVANNAH, GA.

Colonel D. George Paston
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

The closing of the U. S. Public Health Service Hospitals and Clinics for inability to provide high quality medical care and also for economic reasons in my opinion is not justifiable.

First, to state that the hospitals and clinics are not providing high quality medical care is a direct insult to the fine, dedicated, highly skilled individuals staffing these facilities. I have been associated with the U. S. Public Health Service since 1961 and during this time I worked directly in the hospital located here in Savannah until it closed in July 1969. Since then I have been the Administrator of the present Outpatient Clinic which continued functioning after July 1969.

Prior to the closing of the hospital, the staff here worked directly with the outpatient clinics located in Charleston, South Carolina, Atlanta, Georgia, Jacksonville, Miami, and Tampa, Florida. Since the closing, we have worked with the PHS Hospital located in Norfolk, Virginia, and we are still completely supporting the clinic located in Charleston, South Carolina, and furnishing medicines and drugs to the clinics in Jacksonville, Florida, and Atlanta, Georgia.

My purpose in making these statements is in all this time and all the many patients that have been treated in these hospitals and clinics, there have never been any major complaints about the quality of care they have received. But more than that, I have seen for myself what has been done and I cannot conceive how this conclusion could be reached that medical care was anything but good. If it was anything else, some group or agency receiving the benefits would certainly have made it known. The Maritime

Union(American Seaman), or the U. S. Coast Guard are not advocating closing the facilities and they are both primary beneficiaries of the services rendered. Other beneficiaries such as retired military personnel, BEC(Bureau of Employees Compensation), Coast and Geodetic Survey, PHS Commissioned Corps, Immigration, etc., who are all receiving medical care at these facilities have never complained of the quality of care received, so I am at a loss in the reasoning of making this a factor for closing. I am not going to elaborate on the professional abilities of the staff members, all are required to meet the same standards established for each profession that is required in private hospitals and other medical facilities.

Secondly, in regards to the facilities available, prior to the closing of the hospital located here in Savannah, we could not have required more modern up-to-date equipment to enable us to provide the services we were staffed to give. This can be substantiated by the equipment records. As for the Outpatient Clinic as it now is functioning, it is well equipped with modern facilities to provide good, efficient treatment. This facility is definitely not under utilized. We were set up for an estimated 13,000 outpatient visits a year in July 1969 and as of this date we will average 24,000 visits this fiscal year, almost double.

We have examining rooms, two (2) minor emergency rooms, oxygen therapy, a pharmacy(91,300 workload units), a well equipped laboratory(17,000 procedures), an x-ray department(2,500 procedures), dental clinic(4,500 procedures), physical therapy(3,300 procedures), and medical records. We also have an administrative staff to support these services.

If the hospitals and clinics are closed, the patients will have to be treated at private hospitals and doctors' offices. In this community they are already overcrowded. Even if it were more economical, the medical care will certainly be harder to obtain.

One other point I would like to bring to your attention. The two enclosed documents speak for themselves. The one by Secretary Richardson making the announcement on considering the closure of the hospitals and clinics dated December 30, 1970, and the other, an Act(S.4106 Manguson-Rogers

Emergency Health Personnel Act] signed by President Nixon to revitalize the Public Health Service and broaden its mission dated January 4, 1971. Both major proposals having opposite meaning, to close on one hand and broadening its mission on the other.

Sincerely yours,

D. R. Bostwick
Administrative Officer

Enclosures:
Memorandum
Statement

EXHIBIT 7

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

MEDICAL OFFICER IN CHARGE
USPHS OUTPATIENT CLINIC
NCDC BUILDING NO. 1, RM. 894
ATLANTA, GEORGIA 30333

Jenuary 21, 1971

Col. D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Pastoo:

It hae come to our attention that Washington is consideriog cloeing our Public Heelth Servics Clinic. We feel thie would be a grave error since this perticular clinic eeee many beneficieries every year. In the fiscal year of 1970 the Atlanta Public Heelth Service Clioic saw 14,854 petiente. Of these, ooly 166 were Americen Seamen, and 173 were Coast Guard Officere. The rest were active and retired militery depeodsnts, Federal employeee, immigrante, Public Health Service Officers, and emergency caeee. This clinic is cloeely affilieted with the Netion Center for Dieeese Control eod should the clinic be closed all of ite eligible dependents would have to go to the Veterans Administration Hoepitel or to Fort McPherson, a 45 minute dsive from the Center. We hsve beeo in cootect with the Fort and their facilitiee are, at present, completely overloaded and the ueual weit, eccording to maoy who heve beeo thers, is greater than 2 or 3 houre. By treatiog the Federal Employees here at the Center for Diseeee Control we probably eave the government many timee the cost of the clinic for the employes ie off ths job for only e few mioutee for mioor probleme ee oppoeed to the entire dey ehould they have to coosult e privete doctor. Needleee to eey the 14,854 people who were eeen doee not ioclude the numberoue phons cells end consult work which ie provided by the clinic.

When problems eriee and some epscialy training is required we generally refer the petient to the nearest Public Heelth Service Fecility or to e private doctor. However, ths wait to eee a privete phyeician ie usually quite loog, except under the moet emergent of conditione, therefore, to add ao additional 15,000 petieots to an elready overloedsd medicsl system seems to be rather illogicel eod also rether expensive. Here et the clinic we read our own X-reys end electrocardiograms, esving the government $800 to $900 per mooth.

Io coojunction with ths CDC Sefety Officer we elso monitor the Public Heelth Service Officers and Fsderel empbyees who deal with hazsrdous agents. We have eo over-view for any epidemice or problems which could eriee here at the Center. Thie perepective would be lost ehould everyone have to esek his own individual physician.

While there are many other services which this clinic provides, nevertheless, I am sure you will agree that closing it would be rather premature and, in my opinion, a mistake. While we agree that the system needs revision, one should not take such actions without considering each individual clinic. The "CDC Clinic" is more than merely a PHS Clinic since we serve the government by seeing Federal employees and saving many man-hours of work, in addition to performing our regular duties. Although the Veterans Administration System gives adequate hospital care, my experience is that the outpatient care is somewhat lacking and the system would need expensive changes. To attempt to farm these people out to the Veterams Administration would present numberous delays and burdens to those involved.

We would appreciate your support in our efforts to stay active, and should you need further information, please do not hesitate to call.

Sincerely yours,

Jack W. Spitzberg, M. D.

EXHIBIT 8

MIAMI, FLORIDA, PHS CLINIC.

Approximately 57,000 patient visits annually, 1/3 American Seamen, 1/3 military retirees and dependents, and 1/3 active duty personnel and federal employees.

Due to their workload and lack of facilities, the VA hospital is unable to accomodate military retirees.

The Homestead Air Force Base is inaccessible. It is 35 miles south of Miami. Its pharmacy fills approximately 26,000 prescriptions per month and, under Air Force Regulations needs 14 personnel. It has only 5 persons, one of whom is a registered pharmacist.

The Miami PHS Clinic administers 2,000 Yellow Fever immunizations annually.

The Medical Officer in Charge visits the Cuban Refugee Center once a week as a Hematology consultant.

The Physical Therapist also serves as the Center's consultant. Cuban refugees in need of physical therapy are referred to the PHS Clinic. Contractual therapists would charge the government over $25,000 annually for this service.

The PHS Clinic holds regular Hanson's Disease (Leprosy) Clinics to treat an increasingly large number of patients in Dade County afflicted with this disease.

The PHS Clinic assists other government agencies, such as Immigration and Quarantine. This includes deportees in need of medical treatment while in custody of the Immigration Officials. Clinic physicians also accompany deportees to Europe, some behind the Iron Curtain, when medical supervision and sedation is required in the process.

EXHIBIT 9

DEPARTMENT OF HEALTH EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

U. S. PUBLIC HEALTH SERVICE OUTPATIENT CLINIC
226 CHESTNUT STREET
PHILADELPHIA, PENNSYLVANIA 19106

January 22, 1971

Col. O. G. Paston
175 Adams Street
Brooklyn, N. Y. 11201

Dear Colonel Paston:

This is in regard to the recent proposal of the Administration to close the U.S.P.H.S. Outpatient Clinic in Philadelphia.

The population of the Greater Philadelphia Area is approximately 8.5 million people. The several additional facilities available to military personnel are already overburdened.

In addition to the American Seamen and Coast Guard beneficiaries, we are also the authorized agent for Government employees injured on the job. Since there are over 87,000 Government employees in this area, furnishing care to these compensation cases is one of our largest functions.

During the first quarter of this fiscal year we saw 13,697 patients. From July 1970 through September 1970, 16,946 laboratory tests were performed, including 1,050 electrocardiograms. During the same period 1,111 x-rays were taken. This work was done by two full time employees and one part time employee. Likewise, 2,325 prescriptions were filled and 2,354 physical therapy treatments were given.

If the U. S. Public Health Service Outpatient Clinic in Philadelphia is closed, the majority of these services will have to be performed by private institutions and the cost would be prohibitive; for instance, $15.00 per physical therapy visit. The majority of our patients will also have to be seen by private consultants at the going rate of from $15.00 to $25.00 per visit.

As a taxpayer I cannot see the justification for the Government to spend a much larger sum of money to give fewer patients medical care.

In addition, this Clinic also operates an Occupational Health Unit for 25 Government agencies.

Sincerely yours,

Madeline P. Lynch

MADELINE P. LYNCH, M. D.
Medical Director
Medical Officer in Charge

EXHIBIT 10

U. S. Public Health Service Outpatient Clinic
Mobile, Alabama

Background

The Public Health Service Outpatient Clinic was established in Mobile in September 1952 when the old U. S. Marine Hospital (as the PHS Hospital was then known) was closed for lack of funds. Continuous medical care has been given eligible beneficiaries since April 3, 1843, when the first patient was admitted to the hospital. Even during the Civil War when the hospital was used for military purposes, medical care was rendered to American seamen.

Statistics for 1970

During 1970 there were 24,026 visits to the Clinic, 14,730 of which were by American seamen. The majority of the remaining visits were by servicemen, their dependents, physical examinations for other Government agencies, and government employees injured on duty.

There are no other Federal medical facilities (with the exception of the U.S. Coast Guard dispensary) located within Mobile, The closest Federal medical facilities are located about 60 miles away in the following areas:

Naval Air Station Hospital, Pensacola, Fla.
Air Force Hospital, Keesler Field, Biloxi, Miss.
Veterans Hospital, Biloxi, Miss.
Veterans Hospital (Psychiatric), Gulfport, Miss.

The present Clinic is conveniently located in downtown Mobile, easily accessible from the waterfront, and from shipping agencies. Many of the American seamen who come here for treatment have no means of transportation, thus getting to the Veterans Administration Hospital would pose a problem. For lack of funds, many injured fisherman walk to the Clinic, and frequently do not have funds to pay street car or taxi fares to consultants. In many instances these fishermen do not have homes.

Jan. 22, 1971

EXHIBIT 11

STATEMENT BY REAR ADMIRAL R. A. MACPHERSON, USN, COMMANDANT EIGHTH NAVAL DISTRICT, MADE BEFORE HEW COMMITTEE CONCERNING PROPOSED CLOSURE OF PUBLIC HEALTH HOSPITAL, NEW ORLEANS.

19 January 1971

There are approximately 20,500 military personnel, retirees, and dependents within a 25-mile radius of New Orleans authorized to use the U.S. Public Health Hospital. Approximately 6,000 of these are Navy.

These military personnel and dependents utilize about 23% of the inpatient census and 50% of the outpaitent load of the local Public Health Hospital.

If subject closure were effected, the only solution would be to use the CHAMPUS program since other medical facilities in the local area are either not authorized or are already overcrowded now. It is estimated that this would increase costs to the military by about $1 million a year in the New Orleans area. In a telephone conversation I made this morning, a Navy official in Washington stated that of all Public Health hospitals in the United States, closure of the one in New Orleans would hurt the Navy most.

Every District Commandant in the United States and his supporting activities presently have a naval hospital available in the immediate vicinity. The one exception is here in New Orleans. The only military hospitals available in the Gulf area are:

Keesler Air Force Base, Biloxi, Mississippi (two hours distance by vehicle),
Naval Hospital, Pensacola (six hours distance), and
Naval Hospital, Corpus Christi (twelve hours distance).

These are used infrequently because of distance.

Among the fringe benefits enjoyed by military personnel and their dependents is medical care. With the new pay raise just authorized, a Petty Officer Third Class with two dependents, with less than two years service, receives a total of $413.50 per month. With CHAMPUS deductible costs of $50 (for an individual) or $100 (for a family), plus 20 to 25% of all medical costs borne by the individual, this would hurt enlisted personnel and retirees particularly. It is estimated that the average

retiree in the area is a twenty-year Chief Petty Officer drawing about $250 per month retired pay. If the Public Health Hospital is closed, many of these low-income individuals and their families will find their medical costs increased considerably and will undoubtedly suffer financial hardship.

It is strongly recommended that the Public Health Hospital in New Orleans be retained.

R. A. MACPHERSON
Rear Admiral, U. S. Navy
Commandant, Eighth Naval District

United States Public Health Service Hospital, New Orleans, La.

Operating Beds: 403

Workload (FY 1970)
- Average Daily Patient Load: 307
  - PHS Beneficiaries: 207
  - Others: 100
- Outpatient Visits: 145,447
  - PHS Beneficiaries 48,056
  - Others: 97,391

Budget FY 1971: $8,165,118

Per Diem Inpatient Cost (FY 1970): $47.53 (All inclusive)

Outpatient Visit Cost (FY 1970): $8.48 (All inclusive)

Personnel
- Total: 629
  - Commissioned Officers: 140
    - Physicians: 92
    - Dentists: 10
    - Pharmacists: 15
    - Others: 23
  - Civil Service: 489
    - Nursing: 147
    - Dietary: 63
    - Housekeeping: 37
    - Laboratory: 37
    - Radiology: 13
    - Engineering and Maintenance: 38
    - Medical Records: 32
    - Other: 122
  - Commissioned Officer Trainees: 56
    - Medical Interns: 19
    - Medical Residents: 27
    - Dental Interns: 6
    - Others: 4

Facility
- Date of Construction: 1932
- Size of Property: 17.2 acres
- Number of Buildings: 23
- Cost of Modernization: $21.9 million
- Potential Community Use: with alterations -
  - General Hospital
  - Extended Care Facility
  - Community Health Center

AFFILIATIONS

AFFILIATIONS WITH UNIVERSITIES, HOSPITALS AND AGENCIES (Individuals trained under these affiliations are not USPHS employees). This involved at least 490 students and trainees during the past year.

1. ARCHDIOCESAN SOCIAL APOSTOLATE
   Nurses Aides

2. DELGADO JUNIOR COLLEGE
   Home Health Workers
   Other Health Manpower

3. HOTEL DIEU HOSPITAL
   Nursing Students

4. DILLARD UNIVERSITY
   Nursing Students
   LPN Students

5. JEFFERSON PARISH VOCATIONAL AND TECHNICAL SCHOOL
   Dietary Food Service Supervisor

6. LOYOLA UNIVERSITY
   Laboratory Technology
   Dental Hygienist (planned)

7. LOUISIANA HOSPITAL ASSOCIATION AND LOUISIANA STATE NURSES ASSOCIATION
   Nurse Refresher Training

8. LOUISIANA STATE UNIVERSITY
   Physical Therapy

9. NEW ORLEANS PUBLIC SCHOOLS
   Practical Nurse Training

10. ST. MARY'S DOMINICAN COLLEGE
    Diet Therapy

11. SOUTHEASTERN LOUISIANA UNIVERSITY
    Medical Technology

12. TOURO INFIRMARY
    Nursing

13. TULANE UNIVERSITY
    School of Medicine: Residency Training Programs
    Medical Students
    Medical Technology

    School of Social Service: Social Service

    School of Public Health and
    Tropical Medicine: Environmental Health
    Health Services Administration
    Hospital Administration

    Speech Therapy

14. UNIVERSITY OF ALABAMA
    Physical Therapy

15. UNIVERSITY OF FLORIDA
    Physical Therapy

16. UNIVERSITY OF SOUTHERN MISSISSIPPI
    Medical Technology

17. UNIVERSITY OF SOUTHWEST LOUISIANA
    Medical Technology

18. YALE UNIVERSITY
    Ob-Gyn Clinical Clerkship

19. XAVIER UNIVERSITY
    Pharmacy
    Medical Technology

COMMUNITY TRAINING PROGRAMS

The Hospital participates in at least fifteen training programs which are sponsored or funded by the City of New Orleans, the State of Louisiana, the Archdiocese, and OEO (TCA, WIN, etc.)

In the past four years 1414 persons received training in the following categories:

1. CRAFTSMAN HELPERS
2. DENTAL ASSISTANTS
3. DIETARY AIDS
4. EKG TECHNICIAN AIDS
5. EKG TECHNICIANS
6. EMERGENCY ROOM TECHNICIANS
7. FILE CLERKS
8. FINANCE AIDS
9. FOOD SERVICE WORKERS
10. HOME HEALTH AIDS
11. INHALATION THERAPY TECHNICIANS
12. HOUSEKEEPING AIDS
13. KEYPUNCH OPERATORS
14. LABORATORY ASSISTANTS
15. LAUNDRY WORKERS
16. MAINTENANCE WORKERS
17. MEDICAL LABORATORY TECHNICIANS
18. MEDICAL LIBRARY TECHNOLOGISTS

19. MESSENGERS
20. NURSES AIDS
21. NURSING STUDENTS
22. PEDIATRIC PHYSICIAN ASSISTANTS
23. PERSONNEL AIDS
24. PHARMACY ASSISTANTS
25. PRACTICAL NURSING STUDENTS
26. RECEPTIONIST
27. SECURITY AIDS
28. TELEPHONE OPERATORS
29. X-RAY AIDS

The above Community Training Activities are sponsored by:

1. CATHOLIC ARCHDIOCESE
2. DESIRE COMMUNITY MEDICAL CENTER (OEO)
3. MODEL CITIES (Allied Health Program)
4. NEIGHBORHOOD YOUTH CORPS
5. OEO: Summer Aid Program
   Student Work Study Program
   Work Experience Program (New Career Program) - TCA
   Work Incentive Program
   YMCA Extension Residence Program
6. STEP (Supplemental Training and Employment)

INTRAMURAL TRAINING PROGRAMS
PHS HOSPITAL, NEW ORLEANS

1. RESIDENCIES: 39
   - Environmental Health
   - Internal Medicine
   - Obstetrics and Gynecology
   - Ophthalmology
   - Otolaryngology
   - Orthopedics
   - Pathology
   - Pharmacy
   - Radiology
   - Surgery

2. INTERNSHIPS;
   - Dental 6
   - Medical 19

3. OTHER:
   - USPHS Hospital School for Medical Record Librarians, Baltimore - 4

4. TRAINING PROGRAMS FOR HOSPITAL EMPLOYEES (other than medical)
   More than 400 persons attended the following courses and seminars:

   - Air-Sea Rescue
   - Clerical Training
   - Dietary Services Training
   - Equal Opportunity Seminars
   - Housekeeping Practices
   - Labor Relations
   - Medical Self-Help
   - Medical Terminology
   - Middle Management
   - Nursing Seminars
   - Supervision and Personnel Development

SPECIAL SERVICES AND RESEARCH

1. INHALATION THERAPY

2. MEDICAL-SURGICAL INTENSIVE CARE UNIT (including CORONARY CARE UNIT) - 15 beds

3. RADIOISOTOPE LABORATORY

4. RENAL DIALYSIS UNIT - 6 beds (4 patients)

5. TUBERCULOSIS UNIT - 24 beds (22 patients)

A. COOPERATIVE STUDY OF HYPERTENSION - 59 patients

B. COOPERATIVE CORONARY DRUG PROJECT - 103 patients

C. COOPERATIVE STUDY OF RENAL DISEASE AND HYPERTENSION - 64 patients

D. TULANE-USPHS MULTIPHASIC HEALTH TESTING PROJECT
about 150 patients per week

E. COMPUTERIZED COLLECTION OF CLINICAL DATA UTILIZING AUTOMATIC DATA PROCESSING TECHNIQUES

F. THE EFFECT OF PROLONGED SEVERE CHRONIC EXERCISE ON LONGEVITY AND MYOCARDIAL FUNCTION

G. FLAME RETARDANT LINEN PROJECT, COOPERATIVE PROJECT WITH USDA LABORATORY, NEW ORLEANS

The above are some of the 35 research projects currently in progress.

COMMUNITY HEALTH ACTIVITIES AND SERVICES
(incl. voluntary after hours services)

1. ARCHDIOCESE OF NEW ORLEANS - see Training Affiliation
2. CHILDREN'S BUREAU OF NEW ORLEANS
3. CONCENTRATED EMPLOYMENT PROGRAM OF NEW ORLEANS
4. LOUISIANA STATE HEALTH DEPARTMENT HANDICAPPED CHILDREN'S PROGRAM (includes Dentistry, Plastic Surgery)
5. DESIRE COMMUNITY HEALTH CLINIC (limited direct patient care)
6. COOPERATIVE LABORATORY PROGRAM - cooperative quality control program with six laboratories
7. DISASTER ASSISTANCE - natural; e.g., storms, floods, etc.
   other; e.g., fires, explosions
8. ENVIRONMENTAL HEALTH - microbiological sampling assistance to local health care institutions on request
9. FAMILY PLANNING SERVICE - screening of Pap smears
10. HEADSTART PROGRAM - NEW ORLEANS SCHOOL BOARD -- physical examinations
11. HOME FOR THE INCURABLES - physical therapy
12. JEFFERSON COMMUNITY ACTION (KemCo, ShrewCo) - limited direct patient care
13. LOUISIANA DEPARTMENT OF WELFARE
14. LOWER NINTH WARD HEALTH CLINIC - limited direct patient care
15. MEDICAL ADVICE TO SHIPS AT SEA - Coast Guard Search and Rescue Operation

16. MEDICAL SELF-HELP TRAINING - NEW ORLEANS SCHOOL BOARD NURSES

17. MISCELLANEOUS - host to professional associations and Boards

18. MULTIPHASIC HEALTH TESTING PROGRAM (Tulane-USPHS)

19. POISON CONTROL CENTER

20. PREVENTIVE MEDICINE - physical examinations for disadvantaged persons

21. TOTAL COMMUNITY ACTION, INC. - OEO
    Work Incentive Program (Volunteers of America)
    Student Work Study Program
    Summer Aid Program
    Job Corps (YMCA)
    Neighborhood Youth Corps
    Work Experience Program (New Careers)

22. TOURO INFIRMARY - provides administrative experience to dietetic interns

23. TREATING OF NON-BENEFICIARY EMERGENCIES

WORKLOAD DATA BY BENEFICIARY
FY 1970

Beneficiary	Outpatient Visits	Inpatient Admissions	Newborn	Patient Days	Newborn
American seamen	45,410	2,563		71,181	
Coast Guard:					
Active	1,703	229		4,266	
Retired	1,253	52		763	
Applicants	2	-		-	
Lighthouse Service (Retired)	64	4		66	
National Oceanic and Atmospheric Administration:					
Active	6	3		31	
Retired	1	-		-	
Public Health Service:					
Active	937	16		159	
Retired	171	10		258	
Applicants	109	-		-	
Bureau of Employees Compensation	1,219	51		889	
Patients with Leprosy	513	49		1,224	
Special Study (non-reimbursable)	10,503	570		6,004	110
Federal Employee Exam (")	608	-		-	
Emergency (non-collectible)	51	19		169	
Immunizations (non-pay)	577	-		-	
Aliens-Adjustment of Status, etc.	555	-		-	
Food handler & Motor boat operators	1,422	-		-	
Federal Employee Health	1,399	-		-	
Dependents:					
Coast Guard Active	4,940	172	53	860	249
Coast Guard Retired	1,596	44	-	549	-
Coast Guard Deceased	169	1	-	10	-

Beneficiary	Outpatient Visits	Inpatient Admissions	Newborn	Patient Days	Newborn
Dependents (Continued):					
NOAA Retired	1				
Public Health Service Active	1,822	41	18	516	113
Public Health Service Retired	145	3	-	105	-
Public Health Service Deceased	50	1	-	2	-
U.S. Army Active	15,907	557	232	3,665	1,091
U.S. Army Retired	7,443	209	16	2,428	72
U.S. Army Deceased	773	38	3	558	11
U.S. Navy Active	7,358	281	78	1,594	302
U.S. Navy Retired	6,858	172	9	1,527	47
U.S. Navy Deceased	342	12	-	285	-
U.S. Marine Corps Active	2,950	87	39	503	154
U.S. Marine Corps Retired	958	32	2	219	6
U.S. Marine Corps Deceased	89	1	-	21	-
U.S. Air Force Active	5,338	160	51	1,122	266
U.S. Air Force Retired	3,416	87	6	779	22
U.S. Air Force Deceased	163	9	-	101	-
Department of Defense:					
U.S. Army Active	1,614	93		1,200	
U.S. Army Retired	4,703	112		1,837	
U.S. Navy Active	1,398	90		1,251	
U.S. Navy Retired	4,242	128		2,250	
U.S. Marine Corps Active	444	27		321	
U.S. Marine Corps Retired	578	16		240	
U.S. Air Force Active	337	9		212	
U.S. Air Force Retired	2,046	52		1,126	
Foreign seamen	100	65		1,141	
Immigration (reimbursable)	1	-		-	
Indians	-	3		49	
Emergency (collectible)	122	43		581	
VISTA	4	-		1	
Job Corps	13	-		-	
Foreign Service - State Department	7	-		-	
Dependents - State Department	10	-		-	
Peace Corps	18	-		-	

Beneficiary	Outpatient Visits	Inpatient Admissions	Newborn	Patient Days	Newborn
Bureau of Prisons	58	13		198	
Federally Sponsored Community Projects	2,434	5		14	
Tort Claims Act	2	2		16	
National Guard	77	2		4	
Armed Forces Applicants	1	-		-	
Federal Employee Exam (reimbursable)	40	-		-	
Special Study (reimbursable)	370	39		1,915	
Immunizations (reimbursable)	7	-		-	
Newborn	-		215		1,143
TOTALS	145,447	6,172	722	112,210	3,586

Disabled Officers Association

February 1, 1971

President Richard M. Nixon,
The White House,
Washington, D. C.

Opposition to the closing of USPHS Hospitals & Clinics.

Dear Mr President,

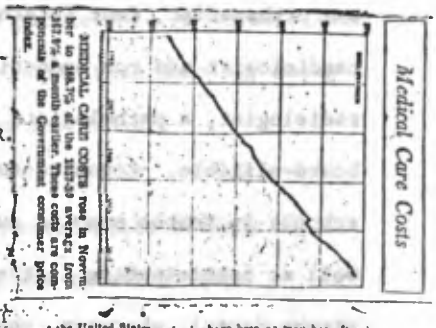
Supplementing my letter of January 28th, I am pleased to enclose herewith the facts concerning the USPHS Hospital at Boston, Massachusetts.

Sincerely yours,

D.George Paston,
Col., AUS-Ret..
Legislative Chairman, Disabled Officers Ass'n

Inclosure: as listed, 8 pages.

copies to:
HEW Secretary Elliot Richardson,
Merchant Marine & Fisheries Committee, H of R.



BRIEFING REPORT

JANUARY - 1971

U. S. PUBLIC HEALTH SERVICE HOSPITAL

Boston, Massachusetts

The Boston Public Health Service Hospital is a 190-bed general medical and surgical care institution located on 14 acres in the Brighton Section of Boston, approximately four miles from the business center of the city and conveniently situated with regard to medical centers, educational institutions and research facilities. It is well served by public transportation in addition to being readily accessible by road and convenient to Logan Airport.

Comprehensive care is given for acute medical and surgical illnesses. Obstetrical care is not given. Full-time specialists on duty at the hospital include two general surgeons, one urologist, one orthopedist, four internists (including one hematologist, one cardiologist and one endocrinologist), an ophthalmologist, a radiologist, a pathologist; all of whom are board-certified or board-eligible. Consultants affiliated with the three medical schools in Boston provide subspecialty care and consultations as well as participating in the teaching programs. In addition, strong dental, pharmacy, physical therapy, dietary, medical records, nursing and social services support the medical care programs.

Patients are drawn principly from American seamen (including fishermen who are actively engaged in care and preservation of the vessel), Coast Guard, active and retired members; active duty military; military dependents, active and retired; and Bureau of Employee Compensation referrals. Non-beneficiaries are treated in research and teaching capacities on a categorical basis. Medical emergencies are treated without reference to beneficiary groups.

Our hospital participates in two research programs funded by the National Institute of Health, ~~Federal Health Programs Service~~ - the Cooperative Pyelonephritis Study and the Hypertension Group Study.

Our hospital is an affiliate of the Boston University School of Medicine. As such both medical and surgical services participate in the clinical training of 2nd, 3rd and 4th year students. Surgical residents are assigned to this hospital from University Hospital as senior residents. We also participate as an affiliate of University Hospital in the Eastern Cooperative Oncology Group as well as the Regional Medical Program for Cancer.

Another important affiliation is the Massachusetts College of Optometry. Several other affiliations are in effect (see appended listing).

Approved training programs provide training of nine rotating medical interns, four dental inters, a four-year program in general surgery, and three year training in internal medicine. Also, we have a hospital pharmacy residency program consisting of two residents for the current year.

Demonstrations and Projects recently initiated at the Boston PHS Hospital include:

- The Family Planning Clinic - recently expanded to three clinics per week. (This clinic provides family planning services to low-income citizens but principally to the Brighton-Allston community).
- College Mental Health Infirmary is located on the first floor of East Hall and is administered by College Mental Health Center of Boston. Provides inpatient care to participants in the plan.
- Coast Guard Rehabilitation Ward - an inpatient care facility to provide intensive care for active duty Coast Guardsmen.
- An innovative program of drug distribution and a modification of the unit-dose system was developed by the pharmacy and nursing services and will serve as a prototype to be installed in all PHS hospitals.

NAME: U. S. PUBLIC HEALTH SERVICE HOSPITAL - 4th oldest in United States(1799)

ADDRESS: 77 Warren Street, Brighton, Mass. 02135 TELEPHONE: (617) 782-3400

CLINICAL SERVICES:

1. Medicine	2. Surgery	3. Dentistry
Cardiology	General	General Dentistry
Endocrinology	Orthopedics	Oral Surgery
Gastroenterology	Urology	
Hematology	Anesthesiology	
Tumor	Otolaryngology	

4. Ophthalmology
5. Pathology
6. Radiology
7. Physical Therapy

MAIN BENEFICIARIES:

1. American Seamen (including eligible fisherman).
2. Coast Guard Personnel - Active and Retired and Dependents
3. Military Personnel - Active and Retired and Dependents
4. Bureau of Employee Compensation Referrals.

WORK-LOAD FISCAL YEAR 1970

ADMISSIONS: 2377 PATIENT DAYS 46,167

DISPOSITIONS: 2361 ADPI. 126.48

OUT-PATIENT VISITS: 58,362

Beneficiery ANALYSIS

	Admissions	Patient Days	OPC Visits
1. AMERICAN SEAMEN (including 11 catagories including eligible fishermen)	682	16,055	13,332
2. COAST GUARD			
Active	495	11,870	5,295
Retired	137	2,404	2,496
Dependents	160	3,169	5,372
2A. PUBLIC HEALTH SERVICE			
Active	11	182	1,001
Retired	5	35	155
Dependents	33	222	1,701
3. MILITARY PERSONNEL			
Retired	150	2,841	4,120
Active	47	581	1,900
Dependents	397	4,432	12,490
4. BUREAU OF EMPLOYEES COMPENSATION			
Referrals	86	1,598	3,376
5. OTHER	174	2,778	7,124
TOTAL	2,377	46,167	58,362

GENERAL INFORMATION

Operating Beds: 190

Workload (FY 1970)

ADPL, Total: 126 (66.3% occupancy rate)
- PHS Beneficiaries: 77
- Others: 49

Outpetient Visits, Total: 58,362
- PHS Beneficiaries: 19,452
- Others: 38,910

Budget FY 1971: $3,929,664

Par Diem Cost (FY 1970): $60.00 (Avarage Length of Stay: 19.6 days)

Outpatient Visit Cost (FY 1970): $14.40

Personnel

Total: 304

Commissioned Officers, Total 60
- Physicians: 33
- Dentists: 9
- Pharmacists: 7
- Other: 11

Civil Service, Total 244
- Nursing: ~~82~~ 78
- Dietary: 35
- Housekeeping: 19
- Laboratory: 14
- Radiology: 7
- Engineering and Maintenance: 16
- Medical Records: 12
- Other: ~~72~~ 63

Commissioned Officer Trainees (included in personnel figures above):

- Medical Interns: 9
- Medical Residents: 4
- Other: 6
- Total 19

Facility:

- Date of Construction: 1940
- Size of Property: 12.6 acres
- Number of Buildings: 11
- Cost of Modernization: $8.7 million
- Potential community use: (with moderate alterations)
  - Extended Care Facility
  - Community Health Center

TRAINING PROGRAMS

I. Training Category

Training Category	Number of Trainees	Training Period
Medical Interns	8	1 year
Medical Residents	3	3 years
Surgical Residents	4	4 years
Dental Interns	4	1 year
Pharmacy Residents	3	1 year

II. Affiliated Training Programs

School	Affiliation	Number of Students	Length of Time
Baltimora PHS Hospital (Record Librarian School)	Medical Record Librarian	3-4	1 month
Blue Hills Regional Technical School	Medical Laboratory Assistant	4	4 months
Boston Trade School for Girls	Dental Assistant	15	5 weeks
Boston University	Physical Therapist	5	2 weeks
Boston University School of Medicine	Medical Students		
	2nd Yr	16	4-5 weeks
	3rd Yr	4	4-5 weeks
	4th Yr	10	1-2 months (as elective)
Northeastern Univereity	Physical Therapist	6	3 weeks
Rindge Technical School	Medical Record Technician	2	2 months
(Proposed) Rosary Hill College (Buffalo, N.Y.)	Medical Records Management	1	1 month

III. Intra-Mural Training Programs

A. Training of Nurees GS-4 (graduates of a 2-year Associate Degree Program - Six months of supplemental training in order to equip them with the necessary knowledge and practice to qualify as a fully functioning member of the nursing team.

III. Intra-Mural Training Programs (cont'd)

B. Day-to-Day

On-the-job training as a regular recurring function or as needed in the following categories:

1. Radiology Technicians
2. Nursing Assistants
3. Operating Room Technicians
4. Food Service Workers
5. Medical Record Clerks
6. Medical Secretaries
7. Medical Transcribers
8. Medical Technicians and Technologists
9. Pharmacy Assistants
10. Physical Therapy Aids
11. Hospital Housekeeping Aids
12. Personnel Technicians
13. Hospital Supply Workers
14. Ward Clerks
15. Accounting Technicians
16. Laundry Workers
17. Hospital Building Maintenance Workers

C. Regular monthly supervisory management training sessions for all first-line supervisors.

D. Regular monthly orientation sessions for all new employees.

EMPLOYMENT OF YOUTHS

in

FURTHERANCE OF COMMUNITY PROGRAMS

1970	*Neighborhood Youth		**College Work Study		Student and Summer Aids	
	Number	Hours	Number	Hours	Number	Hours
January	1	48	21	1082	1	64
February	1	18	22	804	3	175
March			17	995	3	210
April			17	622	3	202
May			15	5558	3	224
June	5	130	16	2170	10	823
July	6	588	15	1918	11	1597
August	7	687	15	1348	9	1093
September			10	333	7	344
October			10	397	5	276
November			8	303	4	196
December			8	295	4	281
TOTAL HOURS WORKES		1471		10,825		5485

* In affiliation with Action for Boston Community Development.

** Current affiliations are with Boston University and Boston College. Past Year affiliations have also included Bentley College of Accounting, Boston State, Brandeis University, Framingham State, Harvard University, Northeastern University, Pembroke College, Simmons College, Smith College and Tufts University.

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

Organized in 1919

NATIONAL HEADQUARTERS
1616 K STREET, N. W.
WASHINGTON, D. C. 20006
202-347-2401

February 11, 1971

President Richard M. Nixon,
The White House, Washington, D.C.

Opposition to the closing of USPHS Hospitals & Clinics.

Dear Mr President,

Supplementing my letters of January 28th and February 1st, I am pleased to enclose the facts concerning the USPHS outpatient clinic at 4th & C Sts., SW., Washington, D.C. (Exhibit 13). You will note that in FY 1970, 84,223 outpatients cost the government $1,477,318, averaging about $17 per patient, including salaries, the cost of drugs and other supplies.

The attached Exhibit 14 are the facts concerning the USPHS Hospital at Galveston, Texas, which had 45,277 outpatient visitors at an average cost of $11.82 and an average inpatient per diem cost of $54.69, far, very far, below the cost in non-Federal hospitals. Another very important factor overlooked is that an applicant must wait 6 or more weeks before being admitted to a non-Federal hospital because of its own patient-load whereas the USPHS hospitals can accept inpatients immediately especially if they are underutilized as claimed.

The Houston and Port Arthur USPHS Clinics serve 25,000 and 8,000 outpatients annually, respectively (page 1, Exhibit 14).

Contrary to the claim that the USPHS facilities are outmoded, the Memphis Clinic is "extremely modern and all new equipment is present in the facility" (Exhibit 15, attached).

We understand that the plan is to arrange with the Veterans Administration or non-Federal contract resources to care for USPHS beneficiaries if the latter's facilities should be closed.

The VA cannot handle USPHS beneficiaries in addition to the VA's own patients. Even now plans are afoot to construct a 1,400 VA bed hospital in Bronx County, New York City (HR 3604), a VA hospital in Queens County, New York (HR 3814), and a VA hospital in Vancouver, Washington (HR 3232). We assume a new VA hospital will be constructed in the San Fernando valley of California to replace the one destroyed by an earthquake the other day.

A proposal to close the available USPHS hospitals and clinics and to shift the patients to non-Federal sources makes no sense since the latter are overutilized and far more costly than the USPHS facilities which are claimed to be underutilized. In 1969, costs in civilian

hospitals averaged $76.35 per patient per day (page 7, my January 28th letter) and, as you pointed out in your State of the Union Message, there is an alarming rise in the cost of medical care, whereas the government pays far less to operate the USPHS facilities.

Use of non-Federal contract resources would be under a program similar to CHAMPUS.

Initially, the CHAMPUS program paid doctors according to what was known as "negotiated fee schedules-fixed rates," periodically negotiated and agreed upon by CHAMPUS and the medical societies of the various States. From January 1967 through May 1968, CHAMPUS phased in "the reasonable fee concept" based on the usual and customary fee charged by a doctor as compared to the prevailing fee charged by physicians in his particular geographic area. In this system, the CHAMPUS program was following the lead of the social security program. Payments by CHAMPUS for surgical procedures rose from 5% in North Dakota to 53% in New Jersey. The median increase was 24% and the additional upward trend followed because the level of physicians' fees has been on the rise appreciably since then. You labelled such rise "alarming" in your State of the Union Message. One doctor in San Diego, California, received $176,000 in one year-1968. As the result of an investigation, the doctor refunded $11,121.75 of the amount paid. Of those physicians and clinics paid over $20,000 by CHAMPUS during FY 1968, 34 physicians and 2 clinics were paid between $20,000 and $24,999, 45 physicians and 7 clinics were paid between $25,000 and $49,999, 6 physicians and 2 clinics were paid between $50,000 and $74,999, 1 physician and 1 clinic were paid between $75,000 and $99,999, and 1 physician, the one above mentioned, was paid $176,000. The salaries paid to USPHS physicians are indeed far less.

Even worse than the much greater cost to the government in non-Federal contractual resources/is there more than a serious doubt, even under contract, whether they are prepared to and would provide USPHS beneficiaries with the same medical care, comparably adequate or as prompt as that provided by the USPHS facilities. Exhibit 16, page 1).

Bellevue, a very large non-Federal hospital, is an example of the treatment we may expect in non-Federal hospitals. (See attached Exhibit 16, page 2).

In the planned program to utilize non-Federal resources, we assume a system similar to CHAMPUS will be adopted. Some of the CHAMPUS shortcomings are demonstrated in the Report by the Subcommittee on Supplemental Service Benefits of the Committee on Armed Services, House of Representatives, 91st Congress, Second Session, July 3, 1970 (HASC No. 91-60). For example, in cooperation with the health insurance industry, the Department of Defense developed a program offered by Blue Cross-Blue Shield. Subsequent to its hearings, the subcommittee learned that Blue-Cross-Blue Shield withdrew from the program thus ending all maternity care under the program (page 9286).

One of the difficulties experienced by patients under CHAMPUS is set forth in a letter of SFC William D. Stephens, Ret., to the Editor of Army Times (Feb 17, 1971, page18) It reads as follows:

'Deductibles'

OMAHA, Neb.: I am SFC William D. Stephens, USA-Ret. This makes me, and my family, eligible for the Champus Program benefits. The supplemental benefits under Champus are $50 per person or can be filed as a family for $100. On the 8th of August 1970 I submitted forms DA 1863-2 for my wife and I under the Champus Family Plan. This was submitted to the Champus office in the Blue Cross-Blue Shield Building in Omaha, Neb. There, they separated the claims and returned them separately. Mine was returned dated Sept. 21, 1970 on a Blue Cross-Blue Shield Form stating, "An outpatient claim should not be filed unless eligible expenses exceed the required during a fiscal year". "The deductible amount(s) are $50 per person, or collectively $100 per family. The fiscal year extends from July 1 to June 30. You have $31.05 for the fiscal year ending June 30, 1970." My wife's claim was returned dated Sept. 21, 1970 and noted, "Please file under your supplimental coverage before filing under Champus". My wife is employed by the U. S. Civil Service Commission and pays to be enrolled in the Federal Plan of Blue Cross-Blue Shield (High Option-Family).

I called the office of Blue Cross-Blue Shield about the first of October and got nowhere; so my wife went over a few days later and she was denied the right to see the Champus representative; and the Blue Cross representative said this is the way the claim must be handled. My wife's must be filed separately from mine as she had met the Blue Cross-Blue Shield deductible.

My total medical was $31.05 and my wife's was $155.15, a sum total of $186.20. Under the Champus Family Plan ($100 deductible) the refund would be based on $86.20. Blue Cross-Blue Shield will not pay on me as mine is under $50 and only pay on $55.15 of my wife's after $100 is deducted.

I am aware that Champus states if you have other insurance coverage they must pay first; however, the supplemental benefits under the Blue Cross-Blue Shield and the Champus Program are not the same coverage.

I cannot see why we must adhere to the $100 deductible per person when we are eligible for the $50 deductible ($100 family deductible).

I believe 20 years of my life for this country is enough, plus the low retirement pay, without being denied rights and benefits of retirement.

SFC WILLIAM D. STEPHENS, Ret.

The USPHS San Diego, California, clinics 39,454 beneficiaries made 25,391 outpatient visits during the first half of FY 1971 (Exhibit 17) . At the USPHS Hospital in Galveston, Texas, the inpatient per diem cost is $54.69 and the outpatient cost is $11.82 (Exhibit 14). I am also pleased to include the facts concerning the USPHS clinics at St Louis (Exhibit 18), at Jacksonville (Exhibit 19) , and at San Pedro, California (Exhibit 20).

The facts in my two previous letters and in this communication compel the conclusion that closing the USPHS facilities and relegating the beneficiaries to other resources will

(a) cost the government millions of dollars more than the continued operation of the USPHS facilities,

(b) endanger the lives and health of the USPHS beneficiaries, and

(c) defeat the government's commitment to provide medical care to the beneficiaries.

It is respectfully submitted that the USPHS Hospitals and clinics should remain open, continue to operate, and be expanded if found necessary and desirable and practical to do so.

Sincerely yours,

D. George Paston
175 Adams St., Brooklyn, N.Y. 11201.

Inclosures: Exhibits 13 to 20 inclusive.

EXHIBIT 13

TOTAL VISITS TO WASHINGTON OPC BY SELECTED BENEFICIARY CATEGORIES, FISCAL YEARS 1968, 1969, 1970. ADAPTED FROM CUMULATIVE MONTHLY REPORT TO DIRECTOR.

BENEFICIARY CATEGORY	FY 1968	FY 1969	FY 1970
American Seamen & Related	581	595	552
Coast Guard Personnel	3,341	4,367	5,789
NOAA Personnel	597	488	357
PHS Officers (Includes NIH)	12,247	12,038	9,981
BEC	33,595	32,809	34,102
FEENP	5,520	2,628	1,756
Army Personnel	728	876	862
Navy Personnel	249	157	139
Air Force Personnel	1,976	2,597	2,585
Dependents - Coast Guard	3,634	3,392	3,385
NOAA	322	307	224
PHS	5,011	4,719	3,381
Army	1,620	1,509	1,558
Navy	774	578	529
Air Force	1,188	1,334	1,492
Immunization and Inoculation, Non-Pay	4,680	4,147	4,538
Aliens & Adjustment of Status	N/A	1,461	1,236
Applicants, Food Handlers	N/A	40	45
Federal Employee Health	PHSFE (179)	528	498
Other Non-Reimbursables	2,594*	671*	843*
TOTAL Non-Reimbursables	78,836	75,241	73,852

BENEFICIARY CATEGORY	FY 1968	FY 1969	FY 1970
Foreign Seamen	---	---	---
Immigration & Naturalization	---	- 1	---
Emergency, Collectible	---	4	15
Job Corps	---	43	112
Federally Sponsored Community Programs	---	---	---
Cooperative Community Programs	---	3,084	4,333
Federal Examination, Pay	N/A	5,646	5,403
Immunizations & Innoculations, Pay	N/A	216	133
Other Reimbursables	5,365**	224**	375**
TOTAL Reimbursables	5,365	9,218	10,371
TOTAL ALL CATEGORIES	84,201	84,459	84,223

*Includes Special Studies, Emergency Non-Pay, ADJS, IA, MBO.

**Includes Vista, Peace Corps, Bureau of Prisons.

TOTAL VISITS TO EACH SPECIALTY CLINIC AND ACTIVITY, WASHINGTON OPC, FISCAL YEARS 1968, 1969, 1970. ADAPTED FROM CUMULATIVE MONTHLY REPORT TO DIRECTOR.

SPECIALTY CLINIC	FY 1968	FY 1969	FY 1970
Internal Medicine	8,469	9,912	8,169
Inoculations	8,125	7,476	8,141
Medical Examinations	4,130	3,304	4,135
Pedicatrics	1,910	1,708	1,553
Dermatology	3,105	2,686	2,298
Allergy	2,490	2,975	3,194
Gynecology	580	605	529
Dental Service, D.C.	6,460	5,754	5,671
Dental Service, NIH	3,975	2,975	3,107
Nutrition	71	106	184
Mental Health	3,319	2,601	1,695
EENT	7,894	---	---
Ophthalmology	---	6,292	5,950
Otolaryngology	---	2,053	4,129
Surgery	21,985	21,465	23,625
Orthopaedics	N/A	453	615
Physical Therapy	13,211	13,261	13,259
Radiology, Total Visits	19,806	17,750	17,180
Exposures	33,594	30,768	30,941
Laboratory Visits	11,269	Not avail.	13,993
Social Service			
New & Reopened Cases	355	224	302
Casework Interviews	934	1,148	1,507
Visits	---	1,134	1,100
941 N. Capital St. Clinic	---	2,989 Oct. 1968	4,154

TOTAL PHARMACY ACTIVITY
AS ADAPTED FROM QUARTERLY REPORTS

	FY 1968	FY 1969	FY 1970
Total Cost Supplies (Drugs) Issued	$62,642.00	$73,315.00	$72,621.75
Clinic	$54,611.00	$61,734.00	$61,083.84
FEHU	$8,031.00	$11,581.00	$11,537.91
Prescriptions & Requisitions, Clinic & NIH	50,004	46,358	44,580
Total Work Load Units	102,060	96,127	97,029
Vslue of Drugs Used at Clinic	$54,611.00	$61,734.00	$61,083.84
Number of OPC Visits	84,201	83,350	82,554
Cost per OPC Visit	0.65	0.74	0.74
Number of OPC Prescriptions	50,004	46,358	44,580
Cost per OPC Prescription	$1.09	$1.33	$1.38

PHS OUTPATIENT CLINIC
WASHINGTON, D. C.

	FY 1969	FY 1970	FY 1971 (Projected)
Salaries & Benefits	$1,030,778	$1,337,316	$1,311,934
Drugs	65,075	71,278	71,280
Other Supplies	44,940	56,598	57,558
TOTAL ALLOWANCE	$1,226,718	$1,477,318	$1,539,554

Average Employment - last 10 months - 106.3

EXHIBIT 14.

Galveston, Texas*

Operating Beds: 160

Workload (FY 1970)
- ADPL, Total: 125 (78.1% occupancy rate)
  - PHS Beneficiaries: 101
  - Others: 24
- Outpatient Visits, Total: 45,277
  - PHS Beneficiaries: 22,707
  - Others: 22,570

Budget FY 1971: $3,350,792

Per Diem Cost (FY 1970): $54.69 (Average Length of Stay: 16.1 days)

Outpatient Visit Cost (FY 1970): $11.82

Personnel
- Total: 270
  - Commissioned Officers, Total: 39
    - Physicians: 24
    - Dentists: 5
    - Pharmacists: 4
    - Other: 6
  - Civil Service, Total: 231
    - Nursing: 78
    - Dietary: 33
    - Housekeeping: 17
    - Laboratory: 10
    - Radiology: 5
    - Engineering and Maintenance: 21
    - Medical Records: 12
    - Other: 55

Commissioned Officer Trainees (included in personnel figures above):
- Medical Residents: 2
- Other: 2
- Total: 4

Facility
- Date of Construction: 1931
- Size of Property: 10.0 acres
- Number of Buildings: 10
- Cost of Modernization: $14.7 million
- Potential community use: with moderate alterations -
  - Extended Care Facility
  - Community Health Center
  - Research Facility for UTMB

*Data received from Headquarters via facsimile transmitter 1-13-71

Houston Outpatient Clinic visits - 25,000/year
Port Arthur Outpatient Clinic visits - 8,000/year

OTHER HOSPITALS IN SERVICE AREA

Hospital	Total Beds	Occupancy (percent)
Danforth Memorial Hospital Texas City, Texas	82	73.0
Galveston County Memorial Hospital Texas City, Texas	315	74.9
St. Mary's Hospital Galveston, Texas	245	89.1
University of Texas Medical Branch Hospitals Galveston, Texas	1061	77.5
St. Joseph's Hospital Houston, Texas	613	95.0
Veterans Administration Hospital Houston, Texas	1332	95.0
St. Mary's Hospital Port Arthur, Texas	177	77.8

COMMUNITY ACTIVITIES

NEIGHBORHOOD YOUTH CORPS (NYC):

The program provides assistance to those who have already dropped out of high school and need job training and motivation. The Galveston PHS Hospital provides the NYC with two years training and experience plus the individual supervisors work closely with the NYC Program Director in providing counseling and job placement.

BOY SCOUTS OF AMERICA:

The Galveston PHS Hospital furnished staff and facilities to perform physical examinations on 180 "disadvantaged" boys, sponsored by the Island District so these boys could attend the special camp, "Invitation to Adventure".

PROPOSED PROJECTS

BOY SCOUTS OF AMERICA:

The Galveston PHS Hospital has been requested by the Island District to sponsor an Explorer Specialty Post (Medical) and also an Explorer Specialty Post (Radio).

GALVESTON COUNTY COORDINATED COMMUNITY CLINICS (4 C's)

The 4 C's will provide comprehensive family medical and dental clinics for all the indigents of Galveston County. The workload of the medical clinic would be 40,000 visits per year. The hospital is ideally located for this project.

MAN IN THE SEA:

The medical portion of the Man-in-the-Sea project could be located at the Galveston PHS Hospital. The facilities would contain compressors and hyperbaric chambers plus a 25 bed hospital unit.

NEIGHBORHOOD YOUTH CORPS TRAINING CENTER:

The Galveston PHS Hospital facilities would be larger, more centrally located and would improve the coordinating, counseling and job-placement activities of the NYC Program.

PHYSICIANS IN GALVESTON COUNTY

Specialty	Private Practice	Group Practice or U.T.M.B.
Administrative Medicine	0	6
Anesthesiology	0	12
Dermatology	0	3
General Practice	16	31
Industrial Medicine	0	3
Internal Medicine	14	32
Family Medicine	0	1
Neurology and Psychiatry	7	14
Neurosurgery	0	3
Obstetrics - Gynecology	2	14
Ophthalmology	2	4
Orthopedics	2	7
Otolaryngology	1	4
Pathology	4	13
Pediatrics	4	10
Plastic Surgery	0	5
Preventive Medicine	0	1
Proctology	0	2
Radiology	3	14
Surgery	4	20
Urology	0	5
Not Classified	19	
Subtotal	78	204

Total: 282

GALVESTON PHS HOSPITAL

TEACHING RELATIONSHIPS

PHS STAFF FACULTY APPOINTMENTS UTMB

Surgeon, John E. Buck, M.D., Clinical Instructor, Department of Surgery

Medical Director, Leo J. Castiglioni M.D. Clinical Assistant Professor Department of Internal Medicine

Dental Director, Biagio J. Cosentino, D.D.S., Clinical Assistant Professor, Department of Surgery, Division of Oral and Dental Surgery

Medical Director, Stanley Graber M.D., Clinical Assistant Professor Department of Pathology

Surgeon, Frank J. Grady, M.D., Clinical Assistant Professor, Department of Ophthalmology

Senior Surgeon, Juan Leal, M.D., Clinical Instructor, Department of Anesthesiology

Medical Director, John R. Mc Kenna, M.D., Clinical Assistant Professor, Department of Surgery

PHS STAFF HOLDING OTHER THAN UTMB FACULTY APPOINTMENTS

Galveston College Associate Degree Nursing Program

Mrs. Anita Satterly

Nurse Officer, William J. Young

Senior Nurse Officer, Rudolph P. Zalesak

University of Texas Dental Branch - Houston, Texas

Dental Director, Biagio J. Cosentino, D.D.S., Clinical Assistant Professor, Oral Surgery

PHS SUPPORTED RESIDENTS

General Surgery Resident (1 Affiliated Resident)

Ophthalmology Residents - 2

Orthopedics Resident - 1

PHS - UTMB AFFILIATED RESIDENCIES

Dermatology Resident - 1

Neurosurgery Resident - 1

Otolaryngology Residents - 2

Urology Resident - 1

COSTEPS (UTMB MEDICAL STUDENTS HOLDING TEMPORARY PHS COMMISSIONS)

Six 10-week appointments are normally available each fiscal year. The areas available are Anesthesiology, Medicine, Ophthalmology, Pathology, Radiology and Surgery.

UTMB MEDICAL STUDENTS ELECTIVE AT PHS HOSPITAL (23 STUDENTS FOR THE YEAR)

1 - Department of Medicine

1 - Department of Ophthalmology

1 - Department of Radiology

1 - Department of Surgery

(10-week periods - one student on each service can be accommodated each period)

MEDICAL AND SURGICAL CLERKSHIPS (80 STUDENTS FOR THE YEAR)

2 - Department of Medicine

3 - Department of Surgery

During their clerkships, one of these junior medical student is on duty with the Officer of the Day until 10 PM weekdays, 9 PM Saturdays and 5 PM Sundays.

PHYSICAL DIAGNOSIS (40 STUDENTS FOR THE YEAR)

A total of 40 University of Texas Medical Branch students during two 10-week periods received instructions in physical diagnosis techniques from Public Health Service medical staff.

MEDICAL RECORD STUDENTS (3 STUDENTS FOR THE YEAR)

3 - UTMB undergraduate students

NURSING STUDENTS (178 STUDENTS FOR THE YEAR)

100 Galveston College students

56 Alvin Junior College students

4 UTMB students (for clinical experience)

18 UTMB students (for orientation)

PHYSICAL THERAPY STUDENTS (48 STUDENTS FOR THE YEAR)

8 UTMB students (1 month training)

40 UTMB students (32 hours training)

GALVESTON PHS HOSPITAL

1. TYPES OF SERVICE PROVIDED BY THE HOSPITAL (INPATIENT CARE BY CLINICAL SERVICES)

Columns indicate total admissions and average daily patient load.

SERVICE	1969		1970	
Dermatology*				
Medicine	1264	54	1395	53
Neurosurgery **				
Ophthalmology	59	2	71	3
Orthopedic**				
Otolaryngology**				
Surgery	1079	57	1106	58
Urology	196	7	201	8
Dentistry	48	2	31	2
Totals***	2555	122	2804	125

* Included in Medicine totals
** Included in Surgery totals
*** Totals exclude intra-hospital transfers and is less than the sum of the admissions to the individual services. Individual services include intra-hospital transfers.

2. NUMBER OF BEDS AVAILABLE TO THE HOSPITAL	1969	1970
Operating bed capacity	160	160
Constructed bed capacity	79	79

3. NUMBER OF PATIENTS PER YEAR

Columns indicate total admissions and average daily patient load

	American Seamen	Bureau of Employees Comp.	Coast Guard	Public Health Service Officer	Special Study	Other	Total
1969	1801 - 96	22 - 1	174 - 7	17 - *	37 - 1	17 - 1	2068 - 106
1970	1942 - 95	11 - 1	153 - 7	10 - *	28 - 1	31 - 1	2175 - 105

Reimbursable	Dept. of Defense	Dependents DOD	Dep. CG ESSA & PHS	Foreign Seamen	Veterans	Other	Total	Grand Totals
1969	144 - 6	221 - 7	77 - 2	27 - 1	15 - *	3 - *	487 - 16	2555 - 122
1970	289 - 9	213 - 8	95 - 2	16 - *	24 - *	3 - 1	640 - 20	2815 - 125

* Average is less than 0.5

4. AVERAGE LENGTH OF STAY FOR HOSPITAL PATIENTS

1969 17.5

1970 16.1

OUT PATIENTS

	Total Visits	AS	BEC	CG	PHS	SPEC. STUDY	DEPT OF DEFENSE	DEP DOD	DEP. CG ESSA, PHS	OTHER	REIMBURSABLE FS	REIMBURSABLE OTHER
1969	43, 632	18,818	217	4038	535	193	5129	8604	4081	1894	48	75
1970	45, 277	19,285	133	2947	342	164	6415	9704	4378	1833	16	60

6. VISITS TO OUTPATIENT SERVICES	1969 -	1970
Dermatology	643	889
General	24801	23180
Medicine	2783	2502
Neurosurgery*		
Ophthalmology	2767	3857
Orthopedics*		
Otolaryngology	259	1373
Pediatrics	23	
Surgery	3092	2840
Urology	935	1276
Dentistry - Total	9221	9147
Inpatients	1908	1715
Outpatients	7313	7432

* Included in Surgery Totals

GALVESTON PHS HOSPITAL

I. INTRA MURAL HEALTH MANPOWER DEVELOPMENT

COURSE TITLE	FULL OR PART-TIME	LENGTH	AUDIENCE DESIRED	BRIEF DESCRIPTION	NO. STUDENTS PER YEAR
Anesthesiology COSTEP	FT	10 Wks.	Junior & senior medical students both as COSTEP and Elective	Supervised clinical experience in anesthesiology	1
Commissioned Officer Orientation Program	PT	12 one hour sessions	Commissioned Officer Personnel	PHS policies, procedures, etc.	18
Community Activities, See: Dietary, Housekeeping Laboratory, Laundry, Nursing, Pharmacy & Physical Therapy					
COSTEP, See: Anesthesiology, Medicine, Ophthalmology, Pathology, Radiology, Surgery and Nursing					
Dental Internship	FT	1 year	Graduates of Class A Dental Schools	Rotating internship	2
Dermatology Resident	FT	6 Mos.	Resident	Dermatology residency	4
Dietary					
Dietary Aides	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in dietary skills and procedures	2
Environmental Health Trainee	PT	1 Hr.	All employees	Elementary bacteriology, food housekeeping procedures, Hygiene	33
Handicapped Trainee	FT	1 Yr.	Mental retardees (Through Texas Rehabilitation Commission)	Supervised training & experience in dietary skills & procedures	1

Emergency Communication	PT	45 Hrs.	Volunteers	Emergency radio communications	8
Employee Training Sessions	PT	10 Hrs.	All employees	Round table discussions on personnel rules and regulations	230
Environmental Health, See: Dietary, Housekeeping Laundry, Maintenance and Nursing					
General Orientation Program	PT	4 Hrs.	New employees	Civil Service policies and procedures, EEO policies and PHS policies and procedures	35
Housekeeping					
Continual Training	PT	10 Hrs.	Housekeeping personnel	Lectures and demonstrations in method improvement	18
Environmental Health Trainee	PT	1 Hr.	All employees	Safety environmental controls, Isolation techniques & body mechanics	20
Housekeeping Aides	PT	10 Wks.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in housekeeping procedures	1
Labor Leader Training	PT	5 Hrs.	Selected Housekeeping personnel	Individual counseling	3
Laboratory					
Laboratory Aide	PT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in clinical laboratory	1
Laundry					
Environmental Health Trainee	PT	1 Hr.	All employees	Safety environmental controls and isolatior techniques and body mechanic:	8

58-997 O - 71 - 19

Laundry (continued)					
Handicapped Trainee	FT	1 Yr.	Mental retardee (through Texas Rehabilitation Comm.	Supervised training & experience in laundry procedures	1
Laundry Worker	PT	10 Wks.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in laundry procedures	1
Maintenance					
Environmental Health Trainee	PT	1 Hr.	All employees	Safety in hospitals; environmental control and body mechanics	22
Safety Training	PT	5 Hrs.	Maintenance personnel	Demonstrations and fire-fighting techniques	22
Medical:					
Clinical Clerkships in Medicine	PT	5 Wks.	Sophomore and junior medical students	Supervised program of clinical experience in patient management	32
COSTEP	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised program of clinical experience in patient management	2
Electives	FT	10 Wks.	Sophomore, junior or senior medical Students	Supervised program of clinical experience in patient management	5
Training Program in Physical Diagnosis	PT	10 Wks.	Sophomore medical school class from UTMB	Lectures and demonstrations in methods and techniques of physical diagnosis	40
Mid-level Management Trainees	FT	1 Yr.	Selected minority employees	Principles of good management	2
Neurosurgery Resident	PT	1 Yr.	Resident	Neurosurgery residency	1

Nursing					
Affiliation Program					
Alvin Junior College	FT	9 Wks.	Student	Supervised training & experience in clinical setting	56
Galveston College	PT	10 Wks.	Student	Supervised training & experience in clinical setting	100
UTMB	PT	8 Wks.	Student	Supervised training & experience in clinical setting	4
UTMB	PT	1 Wk.	Student	Nursing Orientation	18
COSTEP	FT	10 Wks.	Sophomore and junior nursing students	Supervised training & experience in clinical setting	4
Environmental Health Trainee	PT	1 Hr.	All employees	Elementary bacteriology and personal hygeine	30
Leadership	PT	9 Wks.	Graduate of 2 year Associate Degree Nurse Program	Scope and nature of leadership roles in nursing	3
Nursing Aides	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Basic nursing care	3
Nursing Asst. Program	PT	8 Wks.	Nursing Assistant	Basic nursing care	4
On-going In-Service Program					
Audio visual aides	PT	2 Hrs.	Hospital employees	Use of audio-visual aids	13
Monthly Teaching Program	PT	1 Hr.	Nursing staff	Improved nursing techniques	80
Nursing Orientation	PT	As needed	New employees	Nursing procedures	30

Nursing (continued)					
On-going In-service Program					
Orientation Exchange Program	PT	As needed	UTMB nurses	Orientation of nurses in the UTMB Exchange Visitor Nurse Program	
Orientation of Faculty and students from affiliated schools	PT	As needed	As indicated	Orientation to PHS Hospital	185
Pharmacology	PT	2 Wks.	L.V.N.	Basic pharmacology and pharmacy arithmetic	10
Ward Clerk	PT	4 Wks.	Newly employed ward clerks	Orientation to hospital and nursing service	1
Ward Clerk	PT	4 Hrs.	All ward clerks	Coordinate work procedures	4
Ophthalmology:					
Affiliated Residency	FT	1 Yr.	Resident	Ophthalmology	2
COSTEP	FT	10 Wks.	Junior or senior medical students	Ophthalmology residency	
Elective	FT	10 Wks.	Junior or senior medical students	Ophthalmology residency	1
Orthopedics					
Affiliated Residency	FT	1 Yr.	Resident	Orthopedics	1
Otolaryngology					
Affiliated Residency	FT	3 Mos.	Resident	Otolaryngology	4
Pathology					
COSTEP	FT	10 Wks.	Junior or senior medical students	Supervised program of clinical and anatomical experience in pathology	1

Pharmacy					
Pharmacy Aide	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in basic non-professional pharmacy activities	1
Physical Therapy					
Physical Therapy Aide	FT	2 Yrs.	OEO (Neighborhood Youth Corpsenrollees)	Supervised training & experience in assisting physical therapist	1
In-school Training Program	PT	8 Wks.	Physical therapy student	Supervised advanced experience in clinical physical medicine	40
Summer Training Program	FT	1 Mo.	Physical therapy student	Supervised advanced experience in clinical physical medicine	8
Radiology					
COSTEP	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised clinical experience in radiology	2
Elective	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised clinical experience in radiology	3
Summer Employment for Youth	FT	10 Wks.	Selected by Texas Employment Commission	Training and experience	6
Surgery					
Affiliated Residency Program	FT	1 Yr.	Resident	Surgery	1
COSTEP	FT	10 Wks.	Junior or senior medical students	Supervised clinical experience in surgery	
Elective	FT	10 Wks.	Junior or senior medical students	Supervised clinical experience in Surgery	2
Supervisory Management	PT	40 Hrs.	New supervisors	Basic PHS policies, procedures and good management principles	10

Urology Resident	PT	16 Hrs. Per Wk.	Resident	Urology	1

II. EXTRA MURAL HEALTH MANPOWER DEVELOPMENT

Air-Sea Rescue	PT	4 Hrs.	New Commissioned Officers	Coast Guard Coordinated Program	15
Housekeeping	PT	p.r.n.	Selected housekeeping employee	Accredited Housekeeping Program	1
Licensed Vocational Nurse	FT	1 Yr.	Selected nursing employee	Galveston College Program	1
Marine Biological Institute	FT	2 Yrs.	Commissioned Officer	Tektite Project	1

EXHIBIT 15

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE
US PHS OUTPATIENT CLINIC
969 MADISON AVENUE, 9TH FLOOR
MEMPHIS, TENNESSEE 38104

February 9, 1971

Colonel D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

The U. S. Public Health Service Outpatient Clinic in Memphis, Tennessee, is located in a new multi-story building at 969 Madison Avenue on the eighth and ninth floors.

Following closure of the U. S. Public Health Service Hospital in Memphis in 1965, the outpatient clinic remained in the hospital building until February of 1970, when the clinic was moved into its new location. The facilities are extremely modern and all new equipment is present in the facility. In addition to well equipped medical record section, physicians, nurse's office, we have a completely equipped clinical laberstory, clinical x-ray, physiotherapy and pharmacy department. In addition we have a full dental clinic available.

During the calendar year of 1970, we had a patient load of 27,113. Approximately fifty-five percent of the total number of patients seen in our clinic were either active duty or retired military personnel and their dependents. In addition approximately eleven percent of our patients were Bureau of Employees' Compensation cases (government employees injured on the job) and twenty-six percent were merchant seaman.

The other government facilities in Memphis consist of the Kennedy Veterans' Hospital and the U. S. Navsl Hoapital in Millington, Tennessee.

Thank you very much for your interest in our clinic.

Yours very truly,

Robert J. Trautman MD

Robert J. Trautman, M. D.
Medical Director
Medical Officer in Charge

RJT:ew

THE NEW YORK TIMES,

EXHIBIT 16

Medicine

Medicare:

No Cure Yet for Rising Bill

WASHINGTON—President Johnson told the nation on signing Medicsre into law that "no longer will older Americans be denied the healing miracle of modern medicine — no longer will illness crush and destroy their savings — no longer will young families see their owo incomes and their own hopes esten away . . . carrying out their deep morsi obligations — and no longer will this nstion refuse the hand of justice to those who have given a lifetime of service . . ."

That wss the hope of 1965. The reality of four sod a half years of Medicare's operations has dimmed the originsl dresm as the program has become ever more cumbersome aod controversial.

Medical service to Americans aged 65 and over has increased, but in the next fiscal year this group will collectively be paying about as much in out-of-pocket funds for medical care as it paid the year before Medicare began. And there is some danger that they may have to pay more.

For the cost to the Federal Government has soared fsr beyond original estimates — it will resch a total of $30-biilion by summer. And for the next fiscal yesr alone, as seen by medical planners in the White House and the Department of Health, Education and Weifsre, the cost of Medicare will be $9.4-billion — some $400-million above the figure set forth in President Nixon's budget. They hope to mske up the difference by means of a series of economy messures; and that's where the extra pinch msy come for the Medicare pstient.

The exsct means of effecting the economies has yet to be decided, but oblique statements of various Federal officials, including H.E.W. Secretary Elliot L. Richardson, indicate their sights are on reducing hospitalization benefits, increasing the contributions to Medicare from its enrollees, forcing hospitals and nursing homes to economize on services, snd restricting doctors' fees.

These fees, which have been the target of Congressional investigations snd consumer groups for seversl years, were at the heart of a series of letters between Representative Samuel S. Stratton and H.E.W. officials. The New York Democrat said that Medicare beneficiaries were "being cheated" on reimbursements by H.E.W., which, he said, was not paying the share called for in the law. Mr. Stratton complained that while doctors' fees are rising, the Social Security Administration, which administers Medicare, is reducing its percentage of coverage of medical fees.

Social Security Commissioner Robert M. Ball denied Mr. Stratton's charge that revised fee procedures have been "seriously shortchanging millions of Americsn senior citizens." While conceding that some persons are psying more, Mr. Ball said that lack of action by the Social Security Administsrstion in attempting to contain fees "would greatly increase the cost of the program by failing to offer discouragement to increases in charges."

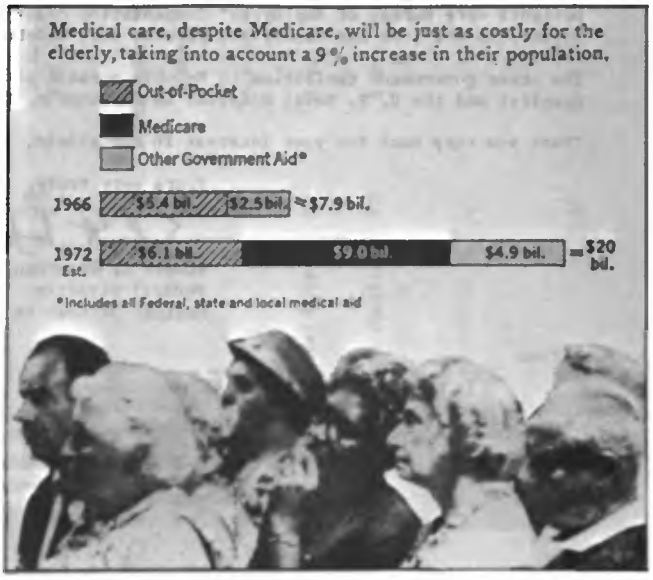
Mr. Ball, Mr. Stratton and other administrators and Congressmen actually are expressing a feeling of exasperstion over ever higher costs and what to do about them. Both the Legislative snd Executive branches of the Government have ordered Mr. Ball in the past few years to crack down on financial inefficiencies and excesses in the Medicare program. But many of the savings are effected at the cost of cuts in benefits snd bring compisints. Medicare, for exsmple, is not supposed to pay for custodial care in nursing homes, only convalescent care. This distinction was widely ignored early in the program, but it is being enforced now smid growing compiaints thst Medicsre recipients are being euchered.

When President Nixon announces the Administrstion's new look health care program, probably at the end of the month, it is expected to cootain some proposals aimed at forcing doctors and hospitals to be more efficient. Hospitals, for example, traditionally operate on a cost-pius basis, meaning that when their costs rise they merely pass the increases along to the consumer. Criticism of this method has mounted. Gordon Chase, New York City's Health Services Administrator, says hospitals should be paid on a "cost-minus" basis, meaning that as their costs rise their productivity and efficiency should also, thus holdiog down dollar outlays.

While criticism of the program mounts, the Nixon Administrstion says the Federal budget cannot abide unending increases in Medicare costs. Even if Congress approves a proposed $383-million cut in benefits, Medicare outlays for the fiscal year 1972 still will go up by $700-million.

"We're very despondent," said Willism Hutton, executive director of the National Council of Senior Citizens, which represents three million of the nstion's elderly. The increased costs of both Medicare and out-of-pocket expeoses, he said, "mean people are not going to doctors because they can't afford it." Speakiog of the new proposals to cut benefits, Mr. Hutton said: "The Administration is trying to balance the budget on the backs of sick old people, and Congress will never go along with it."

—RICHARD D. LYONS



Emergency: Two Approaches

A ward at Bellevue Hospital.

NEW YORK POST, TUESDAY, FEBRUARY 9, 1971

By RON HOLLANDER

Hospital emergency rooms can respond to emergencies this way:

¶Two apartment house fire victims are unloaded from an ambulance at Bellevue with doctors already working over them. They are rushed into an intensive care emergency ward where a epecial burn team is already assembling from different parts of the hospital.

But they also respono this way:

¶A woman in an auto accident is brought to St. Vincent'e by ambulance. She waits two hours before being X-rayed, is released the next morning and told she is fine though she cannot eit up in bed unaided. Thirty-six hours later the hospital calls and saye a mistake was made in reading the X-rays: She has a broken ankle.

¶Her husband hae a cast put on his broken left wrist up to his forearm. After the cast is on the hospital doctor consults a medical manual and finds out that for a broken wrist the cast is supposed to reach above the elbow. The man is brought back and the cast is lengthened.

¶A school teacher arrives at Harlem Hospital'e emergency room with a corneal abrasion on her eye. She waits an hour, complains, is told to go to the eye clinic. There she has to wait because she has been sent from emergency while "these other people have appointments." Sydenham Hospital tells her after an hour it cannot help. Columbia Presbyterian's Vanderbuilt Clinic does help after two hours and completion of a two-page form.

¶An addict comes into Lincoln'e emergency room incoherent with pain after having a tooth pulled. She is told to wait, goes outside where ehe takes an apparent overdose of heroin and is carried back into the emergency room. Two residents, an intern and a nurse'e aide ewarm over her and she recovers.

The two-and-a-half-year-old emergency room at Bellevue sees 60,000 to 70,000 patients a year. As at emergency roome throughout the country, the majority of these patients have colds and viruses and are in the emergency room because their communities lack neighborhood health centers or family doctors.

But at other times the emergency room does what it is designed to do: treat trauma and save lives.

A man ie helped through the waiting room by a friend. He clutches a bloody rag to his cheek which has a three-inch

Continued on Page 46

Emergency Care: It Can Be a Gamble

Continued from Page 3

gash in it. The cut goes through to his mouth and his teeth can be seen through his cheek.

He is takeo immediately to a treetment room where a senior surgical resident checks the wound, determines that no nerve has been injured and turns the case over to an oral surgical intern who is on call.

Assisted by a fourth-year medical etudent, the intern eutures the wound, his hand trembling slightly as he takes etitches. The patient complains of pains in his chest and after the wound is closed he is talked into waiting for chest x-rays, which prove to be negative and he leaves.

"Call B Service"

At 11:45 on a freezing January night the Bellevue ambulance screeches up to the emergency room, its airen going.

"Siren, airen," ahouls the medical resident, grabbing his etethoscope and running to the ambulance bay. Nurses and other doctors converge on the run at the double doors.

"Call B servire," shoute a doctor from the ambulance doors, seeing the burned woman being handed down. B service is a medical team epecializing in burns on call in the hospital.

"OB servire?" asks a nurse, thinking the emergency call was for obstetrics-gynecology.

"No, B!"

Surrounded by M.D.s

The woman is being worked on as her etretcher is wheeled into the emergency ward, a epecial intensive care section of Bellevue'a emergency room. She has at least second-degree burns of the face.

"There'e enother one on the way," a fireman eays from the ambulsnce. "One more, a male; he'e not conscious — breathing about the same way."

The woman is now aurrounded by doctors in tha emergency ward. She la receiving intravenous fluide, oxygen and the amount nf air or "gas" in her lungs is being determined.

She will aurvive but the man will die several daye later.

Earlier in the month, at St. Vincent's, a voluntary hospital which runs an ambulance service for which the city pays, a couple was brought in from an auto accident under the West Side Hwy. at 1:30 a.m. The woman had a eprained back, two eprained wrieis, a broken tooth, chest pains and blacked out briefly after the accident.

Here is her account of her stay:

"Nothing Broken"

She aska for a bedpan but does not get one all night. She is put in a bed in the emergency room'a observation ward. A doctor asks her how she is feeling. She says "awful" and he goes away, ordering a full set of X-rays.

Two hours later the X-rays are taken and she goes to aleep. At 7:30 a.m. she is awakened, told nothing is broken and she can go home. She is in pain, cannot sit up without help and cannot bend her neck. She asks to be allowed to stay but is told the hospital is short on beds and she cannot.

A friend is called and takes her home to New Jersey. The next night the hospitel calls and tells her she has a broken ankle. She gets it set in New Jersey.

Her husband haa his wrist cast put on by a doctor checking in a manual. "Oh, oh, it says if there'a a break in the wrist the cast has to be above the elbow," the man says the doctor said after he had finished the east up to his forearm.

Glass and Dirt

When the man has 14 atitches in his chin whirh were put in at the hospital taken out by his family doctor, the doctor says the wound was not cleaned properly end finds particles of glass and dirt in the wound.

St. Vincent's would not comment on these incidents because they involved "medical-legal problems," accordling to a epokesman. However, ahe did point out that St. Vincent's emergency room handles 50,000 rases yearly, many of them drug overdoses and freak-outs for which it has established a special emergency unit.

No Specialty Care

At Harlem, burdened with a 15 per cent increase in emergency cases in the last year, bringing its yearly total to about 110,000, specialty care such as for eye injuries is not present in the emergency room itself.

As at many hospitals in the city, such specialty treatment is delegated to clinics whirh also serve the community on an appointment basis, giving regular checkups, or to hospitals such as Bellevue or Jacobi in the Bronx which are large enough to maintain medical specialties.

EXHIBIT 17

The U. S. Public Health Service has provided medical care for beneficiaries in San Diego, California since 1888 when the Marine Hospital was established on the site of the Old Hide House in La Playa. This was in the vicinity of the present-day NEL Waterfront Area on Point Loma. This Outpatient Clinic has been relocated several times in the past. At one time, USPHS had medical offices in the Old Post Office Building (Federal Court House Building), still later in the Electric Building, and since 1938 in the New Post Office Building at 815 E Street. The clinic remained there until April 1966, when it was moved to the present location at 2105 Fifth Avenue.

BENEFICIARIES

Through the years various classes of beneficiaries of the Public Health Service have been added by specific Acts of Congress. The following is a partial list of the present beneficiary groups:

American Seamen:

- Government Owned Vessels
- Merchant Marine
- Military Sea Transport Service
- Navy Tankers
- Owner-Operators of Fishing Vessels
- State Maritime Academies and Ships

National Oceanic and Atmospheric Administration

Lighthouse Service, Retired Members

Uniformed Services Personnel and Dependents

U. S. Coast Guard Personnel and Dependents

USPHS Field Employees

Referrals from other Government Agencies:

- Bureau of Employee Compensation
- U. S. Customs Service
- U. S. Department of Labor
- U. S. Immigration and Naturalization Service
- U. S. Maritime Administration
- U. S. National Guard
- Peace Corps Volunteers
- U. S. Post Office Department
- U. S. Department of State

I. TOTAL VISITS BY FISCAL YEAR:

1965	1966	1967	1968	1969	1970	1971*
10,195	12,199	23,944	30,161	32,756	39,454	25,396

II. FY-1970 BREAKDOWN BY BENEFICIARY:

American Seamen	4,755
Coast Guard	4,140
PHS Officers	142
National Oceanic & Atmospheric Administration	99
Department of Defense	1,699
Dependents - CG, NOAA, USPHS	4,558
Dependents - Department of Defense	20,931
Bureau of Employee Compensation	608
Federal Employees (Physical Exams)	263
Innoculations & Vaccinations	1,683
Others	576
TOTAL:	39,454

III. FY-1970 BREAKDOWN BY SEX AND PEDIATRICS:

Male	13,553
Female	14,807
Children	11,094
TOTAL:	39,454

IV. ANNUAL OPERATING BUDGET:

$425,000.00

*First Half FY-1971 (June 30, 1970 - December 31, 1970)

V. STAFFING PATTERN:

A. Commissioned Corps

1 - Director
1 - Senior Medical Officer
4 - General Medical Officers
1 - Physical Therapist
1 - Pharmacist
2 - Dental Officers

B. Civil Service

1 - Administrative Assistant	GS-7
1 - Clerk/Typist	GS-3
1 - Telephone Operator	GS-3
1 - Head Nurse	GS-8
2 - Registered Nurses	GS-7
1 - Licensed Vocational Nurse	GS-4
1 - Laboratory Supervisor	GS-7
2 - Laboratory Technicians	GS-6
1 - X-ray Technician	GS-6
2 - Dental Assistant	GS-4
1 - Pharmacy Assistant	GS-5
1 - Medical Records Supervisory Clerk	GS-6
4 - Medical Records Clerk/Typists	GS-4
1 - Supply Clerk	GS-5

C. Coast Guard

1 - Coast Guard Representative
2 - Dental Technicians

FACILITIES AND SERVICES

The clinic is equipped to provide outpatient medical and dental examinations and care for eelected beneficiaries as authorized by Congrees. The clinic ie composed of medical and dental etaffs supported by a full complex of ancillary services with approximately 50,000 patient visits annually. The eupportive eervices include adminietrative and clerical activitiee, pharmacy, nureing, medical recorde, clinical laboratory, x-ray, phyeical therapy, EKG, and general eervices. Specialty consultation ie also available through the USPHS facilitiee in San Pedro and San Francieco, the U. S. Naval Hospital in San Diego, and thru contract phyeician epecialiets from the local medical community. A preventive medicine program is also in effect for the early detection and prevention of dieeaee, including well baby care and immunizations.

The clinic ie a Designated Yellow Fever Vaccination Center, providing yellow fever vaccinations for international travelers, the eervice being provided without charge to the traveler. The Yellow Fever Clinic ie scheduled every Wednesday at 9:00 AM on an appointment baeis.

Located also within the clinic complex is the Employee Health Unit which providee occupational health eervices for Federal employees of participating agencies in San Diego offering health maintenance examinations and immunizations, including ecreening for visual acuity, glaucoma, audiometry and diabetes.

EXHIBIT 18

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

February 11, 1971

PUBLIC HEALTH SERVICE
USPHS OUTPATIENT CLINIC
1520 MARKET STREET
ST. LOUIS, MISSOURI 63103

D. George Paston
175 Adams St.
Brooklyn, N.Y. 11201

Ref: Memo 2-4-71

Dear Mr. Paston:

The following clinic statistics are for calendar year 1970.

Clinic visits - 15,236

	Active	Retired	Act. Dep.	Ret.Dep.
Coast Guard	2,934	191	1,234	303
Public Health Service	105	21	84	27
U.S.Army	101	253	726	568
U.S.Air Force	136	267	787	521
U.S.Marine Corp.	45	100	281	272
U.S.Navy	18	11	105	87

DOD Total 9,177

The balance of visits, 6,059 are American Seamen, Government Employees injured in the line of duty, etc.

Hope the above is the requested information.

Sincerely,

Veraminette Bareachs

Veraminette H. Bareachs
Administrative Officer

EXHIBIT 19

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE
USPHS OUTPATIENT CLINIC
P.O. BOX 4788
JACKSONVILLE, FLORIDA 32201

February 9, 1971

D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Sir:

The U.S.P.H.S. Outpatient Clinic, Jacksonville, Florida is a small general medical-surgical operation. In Fiscal Year 1970 there were 13,252 patient visits. In Fiscal Year 1969 there were 11,296 patient visits by 4,820 individuals of which 2,008 were American Seamen and 417 were Coast Guardsmen. There was a total staff of 1-1/2 physicians, 2 nurses and 3 clerical to provide these services. X-ray and laboratory services were contracted locally as were emergency inpatient care.

Approximately 18 months ago the clinic acquired additional space with the intention of adding dental, pharmacy, laboratory, x-ray, physical therapy and special consultative clinic services. The space is here, the patient potential and need is here, the costs would be nominal, but because of lack of administrative support our ability to render services is severely limited.

Ambulatory care facilities at other federal installations in this area are severely strained - staff and space-wise. There have been numerous articles in the local press that this county and city needs 150 additional physicians. In fact, the County Medical Service and the Mayor's office made intensive efforts during the recent holding of examinations for licensure by the Florida State Board of Medical Examiners in this city to recruit approximately 150 of the 1,400 M.D.'s being examined.

Sincerely yours,

Charles M. Gillikin, M. D.
Medical Director, USPHS
Medical Officer in Charge

EXHIBIT 20

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

OUTPATIENT CLINIC
335 FEDERAL BUILDING
625 SOUTH BEACON STREET
SAN PEDRO, CALIFORNIA 90731

REFER TO:

February 10, 1971

Col. D. George Paston, Chairman
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Col. Paston:

We have received your letter requesting factual data pertaining to the operation of our clinic here in San Pedro.

This clinic is a facility comprising about 20,000 square feet and offering general medical outpatient services to its beneficiaries. The clinic staff fluctuates between 50 and 60 employees of whom approximately 2/5ths are commissioned officers and the rest are Federal Civil Servants. The commissioned officers in the main constitute the professional staff which consists of 10 physicians, 3 dentists, 2 physical therapists, 1 medical record librarian, and 3 pharmacists. The services provided include laboratory, pharmacy, radiology, physical therapy, dental and specialty clinics such as optometry, ophthalmology, ENT, dermatology, orthopedic, psychiatric, allergy, and well baby pediatrics. With respect to dermatology, a leprosy clinic is conducted at this facility with approximately 100 patients afflicted with this disease being followed or treated at this installation, as well as approximately 500 to 600 family contacts. Patients requiring hospitalization are referred to our hospital in San Francisco or, if local hospitalization is required, use of a contract or local military facility is made.

An average of over 300 patients daily is seen in this clinic for an annual total of approximately 80,000. Of these approximately one-half are American seamen. Military personnel and their dependents with Coast Guard predominating constitute approximately 30% of the case load. Aliens requiring examination for adjustment of their status make up approximately 10% of the case load with the remaining 10% constituting annual and fitness for duty physical examinations on federal employees, and immunizations for overseas travelers and other beneficiaries. In addition, we serve as a yellow fever immunization facility in the Los Angeles area.

As you can see from the above data, even though we are just an outpatient clinic the volume and scope of our functions provide a major health contribution to the populace of this area. In addition to this, of course, is the impact of the $600,000 employee payroll on the economic climate of this community. The relatively sudden closing of this installation could not help but have a disrupting influence on this area.

We appreciate your interest in the plight of the hospitals and clinics and hope that this information will be of value to you.

Sincerely,

Charles J. Buhrow, M.D.
Medical Director
Acting Medical Officer in Charge

CJB:am

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

February 22, 1971.

President Richard M. Nixon,
The White House,
Washington, D. C.

Opposing closing of USPHS Hospitals and Clinics.

Dear Mr President,

Supplementing my January 28th, February 1st., and February 11th letters, I enclose the the facts concerning the

USPHS Hospital, Norfolk, Va (Exhibit 21),
" Clinic, Detroit, Mich (" 22), and the
" Hospital, Baltimore, Md (" 23).

The USPHS Clinic, Portland, Oregon, is 120 miles from the nearest military facility with a physician or dentist. The local Veterans Administration facility, which does not accept active-duty servicemen for care, provides only partial care for the retired. No medicine is provided for a condition not noted on a disability evaluation. This USPHS facility, with 3 physicians, 1 dentist, 1 administrative assistant, 2 registered nurses, 1 technician (Laboratory, X-ray, EKG), 1 dental assistant, and 3 secretaries, averages between 1700 and 1800 patient visits a month. Besides group general medical practice including dental care, it dispenses a wide stock of medicines, is the area center for Yellow Fever immunizations and the area source of information regarding immunizations for international travel, all at a relatively low cost. If this facility were closed and the beneficiaries forced to resort to a CHAMPUS styled program, the cost to the government and the beneficiaries would be exceedingly higher, and most patients would not travel 120 or more miles for routine medical care at a military installation which would defeat the object of preventive medicine to detect the onset of disease as early as possible and halt its proliferation.

Respectfully submitted,

D. George Paston,
175 Adams St.,
Brooklyn, N.Y. 11201.

Inclosures: Exhibits 21, 22, 23.

EXHIBIT 21

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

U.S.P.H.S. HOSPITAL
9500 NAMPTON BLVD.
NORFOLK, VA. 23509

February 10, 1971

Col. D. George Paston
Disabled Officers Association
175 Adams Street
Brooklyn, N.Y. 11201

Dear Col. Paston:

In response to your letter of February 4, 1971 requesting facts and statistics about the Norfolk Public Health Service Hospital, the following information is supplied:

1. Fiscal Year 1971 Budget - $4,052,255

2. Cost per Average Patient Day - $61.04 - all inclusive

3. Cost per Outpatient Visit - $9.13 - all inclusive

4. Personnel - 332

   a. Commissioned Officers - 42
   b. Civil Service - 290

5. Average Daily Patient Load - Fiscal Year 1965-70

	Total	Primary 1/	Secondary 2/
1965	169	112	57
1966	158	104	54
1967	138	93	45
1968	133	89	44
1969	127	85	42
1970	142	95	47

6. Outpatient Visits - Fiscal Year 1965-70

	Total - All Beneficiaries
1965	72,998
1966	76,453
1967	75,425
1968	86,088
1969	85,704
1970	92,983

7. Operating Bed Capacity - 210

1/ Primary Beneficiaries include American Seamen, Bureau of Employees Comp., Coast Guard and PHS
2/ Secondary Beneficiaries include Dept. of Defense Active Duty, Foreign Seamen, Veterans Admin. and Dependents and Retired Personnel of Dept. of Defense, Coast Guard, NOAA and PHS

B. Training Programs -

a. Eight (8) Rotating Medical Internships
b. USPHS Co-Step Training Program in Medicine, Dentistry, Physical Therapy, Social Work, Pharmacy and Medical Records
c. Nursing Education of Nursing Students

(1) Old Dominion University, Norfolk, Virginia
(2) Norfolk State College, Norfolk, Virginia

d. Social Service Education

(1) Richmond School of Social Work, Virginia Commonwealth University, Richmond, Virginia

e. Physical Therapy Clinical Education

(1) Virginia Commonwealth University, Richmond, Virginia
(2) University of Pennsylvania, Philadelphia, Penn.
(3) Marquette University, Milwaukee, Wisconsin

9. General Statement - This hospital is a well equipped general medical hospital, capable of providing a full range of medical service. Those services not available (psychiatry, neurology, neurosurgery, etc.) at the hospital, are readily available from community physicians on a contractual basis. Although structurally old (built in 1922) the building is functionally and structurally sound. This hospital is as fine a hospital as one could find of comparable size in this area.

Hopefully, this is the type of information you have requested. If not, please feel free to contact us for further detail.

Thank you for your very welcome interest in our hospital.

Very truly yours,

John N. Bowden
Asst. Admin. Officer

JNB:sc

EXHIBIT 22

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
USPHS Outpatient Clinic

ADDRESS REPLY TO:
MEDICAL OFFICER IN CHARGE
U.S. PUBLIC HEALTH SERVICE HOSPITAL
1200 RIVERSIDE
DETROIT, MICHIGAN 48215

February 12, 1971

Col. D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Col. Paston:

The USPHS Outpatient Clinic in Detroit is a general clinic authorized 38 positions of which 36 are now filled. We have four staff physicians and two dentists. We have X-ray, laboratory, physical therapy and pharmacy sections. We have a full consultant staff available for our primary beneficiaries which include the American Seamen, Coast Guardsmen, and PHS personnel along with a few other smaller groups. These ancillary services are not normally available for Department of Defense personnel and their dependents or other so called secondary beneficiary groups because the cost is prohibitive. Secondary beneficiaries are seen on an availability basis for whatever services we have within the clinic, but we do not assume additional expenses or make additional arrangements for the patients.

The Clinic is located on the far east side of Detroit on the Detroit River as it opens into Lake St. Clair. It is easily accessible from the metropolitan area by automobile, and accessible by public transportation with only moderate delay and difficulty.

Our average daily census ranges from 113 to 177 patients. Dependents and Department of Defense including active duty and retired servicemen, vary from 1200 to 1500 visits per month. Many Department of Defense beneficiaries use the CHAMPUS program for both outpatient and inpatient care. Any patients followed in our Clinic who require hospitalization make their own arrangements for such hospitalization and either use personal insurance or the CHAMPUS program. The Public Health Service is only responsible for hospitalizations of primary beneficiaries. I understand from a number of patients that have used the CHAMPUS program that the delay in payment to the doctor or hospital is large as is the delay in reimbursement if the patient has paid the charges directly. The paper work is also rather involved. The deductibles required of the patient are often large and constitute s financial hardship but this department is not directly involved with that program and we are unable to make further comment or recommendation.

The VA hospital is located in Allen Park which is approximately 12 miles west of Detroit. It is also readily accessible by private transportation but is poorly accessible by public transport. Any questions you have concerning the capabilities of the VA hospital would be better referred to the Director of that hospital, Dr. Bernard W. Robinson, VA Hospital, Allen Park, Michigan 48101. The capacities and capabilities of the non-federal hospitals are variable. We have no statistics in this regard in the local office. I would suggest that the Office of the Secretary of DHEW may have more information.

I trust that this additional information will be helpful to you in preparing your report.

Sincerely yours,

M C Woodbury

Margaret C. Woodbury, M.D.
Medical Officer in Charge

EXHIBIT 23

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

DIRECTOR, PHS HOSPITAL
U.S. PUBLIC HEALTH SERVICE HOSPITAL
7500 SYNAN PARK DRIVE
BALTIMORE, MARYLAND 21211

February 12, 1971

Mr. D. George Paston
Chairman
Disabled Officers' Association
175 Adams Street
Brooklyn, New York 11201

Dear Mr. Paston:

Reference is made to your letter of February 4, 1971, concerning statistical data regarding the U.S. Public Health Service Outpatient Clinic, Pittsburgh, Pennsylvania.

The following statistical information is furnished:

	FY 1970	FY 1971
Annual Budget:	$115,552.00	$95,623.00
Total No. of Employees:	7 on duty 1 in training	6 full time 1 part time
Total No. of Visits:	7,850	3,676 (July 1 - Dec. 31, 1970)

Sincerely yours,

for Edward J. Hinman, M.D.
Director

Mr. ROGERS. Thank you very much, Colonel Paston for an excellent statement.

Mr. Nelsen.

Mr. NELSEN. In the language of many good Americans I think you are cooking on the front burner. I believe what you seek to do is to make that hospital totally available, and you don't want to lose the Government's involvement for several reasons. We may have to do some changing of the laws to do this, but at least I think your purpose is to be lauded and I compliment you and thank you for your statement. It is a very sensible one and practical one.

Colonel PASTON. Thank you very much.

In other words, we want these hospitals maintained, expand their service, but maintain their present ability and willingness to conduct these hospitals by giving good medical service. Once you turn it over to local people, once you contract it out, we will not get good medical service. Another thing, if I may, the rumor was that they were going to close which was a terrible thing to the PHS personnel. I have spoken to many doctors in the U.S. PHS hospitals and other personnel, and they are alarmed. Many of them are quitting their jobs. The whole system may be ruined unless Secretary Richardson makes it emphatic immediately to his personnel, doctors, and others, that they are not closing, that they will expand if anything.

Mr. ROGERS. Thank you very much.

It has been most helpful. I know the members of the committee will appreciate your being here and giving this very helpful testimony. Thank you very much.

Colonel PASTON. Thank you very much.

Mr. ROGERS. There is a quorum call on the floor. We have one more witness, Mr. Moody, who is the administrator of the AFL–CIO Maritime Trade Department. So I understand that you would like to testify tomorrow?

Mr. MOODY. I would appreciate the opportunity very much, Mr. Chairman.

Mr. ROGERS. Thank you. We will be glad to arrange for that and we will be glad to hear you tomorrow.

Mr. MOODY. Thank you.

Mr. ROGERS. The committee will stand adjourned until 10 o'clock tomorrow morning.

(The hearing adjourned at 12:25 p.m. to reconvene at 10 a.m. on Thursday, March 11, 1971.)

OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

THURSDAY, MARCH 11, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2325, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing our hearings on resolutions expressing the intent of Congress that Public Health hospitals and clinics not be closed.

And we are very pleased this morning to have as our first witness one of our colleagues who is vitally interested in this matter and has taken a great deal of interest and leadership in trying to do something to prevent the closing of the clinics and the hospitals, our colleague from Florida, the Hon. Dante B. Fascell.

Congressman Fascell, we are honored to have you here. And we will be pleased to receive your comments.

STATEMENT OF HON. DANTE B. FASCELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. FASCELL. Mr. Chairman and members of the subcommittee, permit me a personal reference at the outset by saying that I am delighted that my colleague from Florida has obtained the chairmanship of this subcommittee. I commend him not only for the work that he is undertaking with respect to these hearings, but also because I am familiar with the outstanding leadership that he has given in the entire field of health during the years that he has been on this entire committee. And I am very pleased to follow his distinguished leadership in this whole area. He and the subcommittee have made significant contributions to the entire problem of improved health facilities in this country. Since it is one of the paramount problems confronting the American people today. I cannot think of a better place to spend your time and talent than the way you gentlemen are in considering all of these many problems.

These hearings, therefore, are timely and important. It seems to me that it is time in this country when it is almost obvious beyond question that what we need to do is increase and improve hospitals, hospital administrations, and health care facilities and treatment for individuals in this country.

It is almost gross to say that by closing the public health hospitals or the outpatient clinics because of whatever the problems are in terms

of being outmoded or outdated or otherwise, we would solve the problem. And one must raise another question mark particularly when, if there is no provision for alternatives as indicated by the administration in the budget. It does not take a genius to figure out that it would take 2 or 3 years to go through the budget process to create the alternatives unless you are going to transfer them, by contract services to other facilities.

I don't know what those facilities would be. I know in our area we would be hard pressed. For example, at the VA it would be almost impossible. We cannot get the personnel now to do the job that the VA needs to do in Miami. And we cannot open the beds that we need badly in Miami because we do not have the money to do that. So I do not know how you could transfer what the outpatient clinic in Miami is doing, for example, to the VA hospital or other Federal facilities for even the contract amount, because obviously the contract amount would not decrease the cost, it would probably increase the cost. And I am sure that there would be no increase in service.

So for all of those reasons, it seems to me it is a peculiar tack that has been taken with respect to budget juggling on this issue. And it was for that reason that I joined our colleagues, 150 members, I believe, in sponsoring a resolution urging the administration not to close the PHS facilities, to keep them open, and to make the necessary budget adjustment without any equivocation. If we are talking about national priorities, I cannot think of one any greater than the priority of health.

It seems to me we ought to quit playing games with health. And that is what this boils down to as I see it, it is a kind of gamesmanship with respect to a vital service in the field of health.

Take the Miami outpatient clinic. We had 47,000 beneficiaries through that clinic last year. The estimated increase next year will be to 55,000. There are 32 people on the clinic staff. The staff has been reduced. The budget is $502,300 for fiscal year 1971, and with no budget request for fiscal 1972.

As you know, Mr. Chairman, the Miami clinic is the only place where treatment for dormant leprosy is obtainable in Florida. I do not know where else they could go after that.

In addition to taking care and providing for immigration and quarantine services, there is also the care provided and the services provided with respect to the Cuban refugees.

So all in all, it is obvious that that clinic, as all of the others do elsewhere, provides a very valuable service. It is a service which the Federal Government has the primary responsibility for.

And therefore the only sensible thing, it seems to me, to do would be to at least provide for the funding of those facilities until such time as an acceptable alternative is proposed and agreed upon. To cut off the funds without an acceptable alternative does not seem to me to be making progress. It seems to me it would be going backward.

That is the obvious thrust, I am sure, of all the testimony which this distinguished subcommittee has heard. I add my voice for that purpose, and strongly support what you, Mr. Chairman, and the members of this subcommittee are doing to change the administration's viewpoint. I understand that you have been successful in doing that at least temporarily. I congratulate you for it. I hope you will continue to be successful.

(Mr. Fascell's prepared statement follows:)

STATEMENT OF HON. DANTE B. FASCELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman and members of the subcommittee: I appreciate being able to submit my statement to this distinguished subcommittee. May I say at the outset that I am pleased and proud to see my colleague and fellow Floridian, Paul Rogers, chair this important subcommittee of the Interstate and Foreign Commerce Committee. Mr. Rogers is to be congratulated not only for his selection as chairman, but for the leadership he has shown in bringing our attention to this threat to the Public Health Service facilities and personnel.

I have a special interest in the rumored closing of eight Public Health Service hospitals and thirty clinics, because one of the clinics is located in my district in Miami, Florida. But even if this were not the case, I would be very concerned about any plan which proposed to eliminate health facilities at a time when our nation is already experiencing shortages and serious gaps in its necessary health services.

This is the spirit in which I joined over 150 of our colleagues in sponsoring House Concurrent Resolution 152, expressing the sense of the Congress that Public Health Service Hospitals and outpatient clinics remain open and that additional funds be made available to provide the best possible medical care for beneficiaries.

What began as a gap between rhetoric and reality in the present Administration's commitment to expanding our nation's medical capabilities and facilities has developed into a wide chasm in the case of the lack of funding for public health service facilities in the budget submitted to the Congress by the President.

Mr. Chairman, I know the subcommittee has received testimony from expert officials and others more directly involved with the Public Health Service, but I believe that I can contribute to these hearings by providing a picture of the services rendered by the Miami outpatient clinic. I would respectfully remind the subcommittee that these are services which would be difficult and costly to transfer or contract out.

The Miami outpatient clinic treated over 47,000 beneficiaries in fiscal year 1970. In fiscal year 1971 it is estimated that the clinic will service over 55,000, a marked increase despite the fact that the clinic experienced a $20,000 cut in funds and was authorized one less staff position this year.

In addition to normal medical services, the clinic performs functions outside the health needs of its primary beneficiaries—merchant seamen, federal employees injured on the job, and uniformed service personnel and their dependents. These "extras" include free yellow fever shots for Americans about to travel abroad, physical examinations for aliens applying for citizenship, and treatment for federal prisoners awaiting trial or transfer.

The Miami clinic is the only medical service in Florida for the treatment of dormant leprosy. Those suffering from this affliction depend on the Public Health Service Clinic for the special medication which allows them to lead normal lives.

Immigration and Quarantine officials also depend on the Miami clinic for their medical needs as they arise, even to the point of having PHS personnel from Miami accompany ailing deportees to their destination. In one case, this involved traveling behind the iron curtain.

Perhaps the most valuable service rendered by the Miami clinic is its contribution to the welfare of Cuban refugees. In this regard the Clinic supplies a clinical blood specialist and a physical therapist for the Cuban Refugee Center in Miami. It is estimated that these services, if contracted out to private physicians or institutions, would cost the government more than $35,000 per year.

I would like to call the attention of the Subcommittee to the letter from Mr. Elmer Staats, Comptroller General of the United States, to the Honorable Edward Garmatz, Chairman of the Merchant Marine and Fisheries Committee. The letter concerns the legal authority of the Department of Health, Education and Welfare, to close or transfer the services of Public Health Service Hospitals and clinics.

The Comptroller General concludes in his letter that the Secretary may not close *all* PHS hospitals and facilities by means of transfer to non-Federal ownership. This leaves open the possibility of closing some of the hospitals and clinics, as is presently being considered by HEW. In addition, the letter states that the authority to provide care for PHS beneficiaries in other than PHS facilities exists only when there are overflow conditions or when beneficiaries are remote from service facilities. By closing PHS hospitals and clinics, beneficiaries are

automatically made remote from facilities. I believe this is a "back-door" approach to compliance with legal requirements.

Finally, Mr. Staats' letter holds that the authority to arrange for cross-servicing of PHS beneficiaries by VA hospitals is based on the VA facility being "in a position to supply or equipped to render" the needed services. I might point out that the administrators of both the VA hospital in Miami and the Homestead Air Force Base Hospital have stated that they have neither the space nor the personnel to take over the care of present PHS beneficiaries.

As a matter of fact, because of budget cuts during this past year, the Miami PHS clinic has had to restrict its 15 most expensive drugs to active duty personnel only. This has resulted in other beneficiaries having to go to the Homestead Air Force Base Hospital for these drugs. There the prescriptions given out per month have risen to 26,000, and Homestead Air Force Base officials had to request additional funds to meet the demand. The funds were granted.

Mr. Chairman, whether or not plans to close Public Health Service facilities are carried out by the Administration, I think it is important that the Congress demand that present services of the type performed by the Miami outpatient clinic not be "starved" out of existence by budget cutting and fiscal chicanery.

We are rightly concerned about the possible closing of Public Health Service facilities. The imaginary savings to be realized by the Government would seem to be coming from an elimination of services, despite all claims to the contrary. We can see that attempting to provide these services by whatever alternatives proposed by the Department of Health, Education, and Welfare, will result in increased—not decreased—costs.

I hope the Subcommittee will act favorably on House Concurrent Resolution 152. Public Health Service personnel and beneficiaries are looking to the Congress for protection of their hard-earned priority in the allocation of our nation's resources.

Thank you very much for your attention.

Mr. ROGERS. Thank you, Mr. Fascell, for an excellent statement.

And I think this is true, that it seems to be some type of gamesmanship when the budget comes in with no funds, and yet we hear HEW say, well, they are really not going to close them. It does not make sense. So we are trying to get something very concrete in a way. And it may be that the Congress itself—and I think this probably will be true—will just have to go ahead and appropriate the money. And those of us who know what the problem is I think will have to take the battle to the floor. And we certainly will count on you, considering the fine help you have given us before.

Mr. FASCELL. That seems to be a perfect solution, Mr. Chairman. It may be that that is the way the administration had in mind in the first place. It would take the onus away from them. And if that is what is going to be done, then we should go ahead and do it.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you for your testimony. It sounds very good to me.

Mr. FASCELL. Thank you.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. No questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. No questions.

Mr. ROGERS. Thank you very much. We appreciate your help.

Mr. FASCELL. Thank you.

Mr. ROGERS. Our next witness is the Honorable John L. McMillan, the distinguished chairman of the District of Columbia Committee. Welcome, Mr. Chairman, I believe you have a short statement you wish to present to the committee this morning. Please proceed as you see fit, sir.

STATEMENT OF HON. JOHN L. McMILLAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Mr. McMillan. Mr. Chairman and members of the Interstate Commerce Committee, I want to congratulate you and the members of your subcommittee on the interest you are expressing in connection with Public Health centers located throughout the United States.

I can't think of any worse tragedy that could be imposed on the wives of servicemen and the public in general, if the proposal to close these clinics and health centers would be carried out; especially when we are spending millions and millions of dollars trying to iinprove the health of our citizens at this time. A proposal of this nature certainly does not make sense to me.

These centers are understaffed and overworked, and I hope that you will authorize the Appropriations Committee to double the funds necessary to operate these centers and clinics. I know they are performing a wonderful service for thousands of people who really are not financially able to get proper medical attention otherwise. I am happy to appear before your subcommittee and offer every assistance possible. I will be glad to join you on the floor of the House in trying to prove to all the Members how necessary it is to keep these clinics and centers open and give them funds to operate properly. Again I want to thank you for permitting me to appear before you. I won't make a lengthy statement; however, I do want to assure you and your subcommittee of my full support.

Mr. Rogers. Thank you, Mr. McMillan, for taking time from your busy schedule to be with us this morning.

Mr. McMillan. Thank you, Mr. Chairman, for holding these hearings.

Mr. Rogers. The Honorable James A. Burke of Massachusetts is our next witness. Welcome, Mr. Burke. Please proceed.

STATEMENT OF HON. JAMES A. BURKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Burke. Mr. Chairman, I request to be recorded as still vitally interested in two House concurrent resolutions on the continuation of the Public Health Service hospitals and outpatient clinics currently being considered by your subcommittee. I am convinced that if it had not been for the filing of resolutions such as 108 and 151, both of which I was proud to cosponsor, a decision might have been made to close the hospitals by now. Quite honestly, I feel that the administration did not expect the outpouring of concern from Congress which followed the December announcement that the Department of HEW was reviewing the continuation of the Public Health Service hospitals around the country.

In the months that followed, I have been deluged with expressions of concern for the future of the hospitals from organizations and individuals throughout the Commonwealth of Massachusetts. They all wrote with one aim in mind—a plea that medical facilities which have provided such excellent service as the Public Health Service hospitals over the years not be closed down. They also expressed bewilderment at how an administartion which was publicly announc-

ing its commitment to providing better health service to the country at more reasonable costs could consider—I repeat, even consider—closing down what are perhaps the only hospitals in the country which have traditionally surpassed both stated objectives of the administration. Every one of the constituents who have written to me expressed complete satisfaction with the quality of service that they have been in the habit of receiving from Public Health Service hospitals. Not one of the constituents welcomed the prospect of having to shift to the already overburdened Veterans' Administration hospitals in the area.

HEW has tried to make out a very strong case that the remaining Public Health Service hospitals in this country have been inefficient and too expensive to operate in this day and age. They have tried to describe them as outmoded and out-of-date. Mr. Chairman, this just does not square with the opinion of people who are getting service from these hospitals. They are not complaining about dilapidated buildings. They are not writing demanding more up-to-date appliances and technological innovations. The Government workers, the Coast Guard men, and the Fishing and Merchant Marine industry in my State over the years have found the hospitals able to provide immediate, highly professional, and somewhat personal service in times of growing lines and depersonalization of service at other Government hospitals. The fact is that to even contemplate turning over the workload of the Public Health Service hospitals to existing Veterans' Administration hospitals is toally inconsistent with the stated aim of HEW and would cost untold millions to the Government in order to accomplish it. The VA hospitals are already overburdened and just cannot deliver the same quality of medical attention to the communities serviced at present by the Public Health Service hospitals at anywhere near the same low cost.

Mr. Chairman, I have said from the outset that one of the beneficial byproducts of having the Public Health Service hospitals in my community over the years is that they have always provided an example of excellent medical service at the lowest possible cost in the area. The existence of such a low-cost alternative has offered incalcuable benefits to those entrusted with the responsibility of determining reasonable medical costs. The Public Health Service hospital has traditionally served as an example of what could be done at less cost to other more expensive medical institutions in the area. In this respect, I was happy to read in yesterday's papers that what some of us have known for some time now, that the Brighton Public Health Service hospital operated at less cost per patient than other Boston area hospitals in 1970. The per diem cost at Brighton was $60 compared with $130 at Peter Brent Brigham, $108 at Massachusetts General, and $70 at the average suburban hospital. What many of us have known to be true for some time has apparently finally been brought to the attention of the Secretary of HEW in a confidential report.

Recent indications are that the administration is backing down on its original plans to dismantle these hospitals. Recent reports are that they will be kept open and their role expanded. They will be given, in all likelihood, not fewer responsibilities, but entrusted with additional responsibilities for the handling of the local communities around them. It seems to me that in times of shortage of good health service,

an administration that was at all serious about its responsibilities for providing health protection to the citizens of this Nation, would be thinking about expanding existing medical facilities which have already proven themselves over the years rather than talking idly of closing them down.

Mr. Chairman, I don't want to take up any more of the committee's time. Let me say in closing that the strong expressions of congressional concern over the past weeks has accomplished much. A comparison of the statements made by Secretary Richardson last December 30, with that made on March 5, readily confirms this. The March 5th statement is a much more positive statement and one which can be interpreted as committing the administration to expanding the role of the Public Health Service hospitals in the years ahead. The one of December, in sharp contrast, read more like a cost analysis prepared by some back-room efficiency expert concerned with eliminating the expenditure of a few dollars at one point in the budget, without any consideration being given to the extra costs which would appear elsewhere as a result of any decision to close the hospitals. I am convinced we have made progress and would only recommend that we do not stop now, but continue our pressure. Right now the best way to do this would be to pass the concurrent resolutions now under consideration by your subcommittee. Thank you for your consideration in recording my views on this important matter of concern.

Mr. ROGERS. Thank you, Mr. Burke, for sharing your views with us today.

Mr. BURKE. Thank you, Mr. Chairman, it has been my pleasure.

Mr. ROGERS. Our next witness is the Honorable G. Elliott Hagan of Georgia. Mr. Hagan, it is good to see you, sir.

STATEMENT OF HON. G. ELLIOTT HAGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. HAGAN. Mr. Chairman, I very much appreciate the opportunity of presenting my views to this committee in favor of the continuation of the Public Health Service hospitals and outpatient clinics and in opposition to planned closings.

In my District in Georgia, in the city of Savannah, we have been fortunate in having a Public Health Service hospital. The hospital was opened in 1906 by the U.S. Government but actually its history goes back to 1875 when hospital services were first provided to seamen in this port city. For many years I have had to fight to keep this facility open. We now have only an outpatient clinic operating and it is far from adequate to the requirements of the area.

Savannah has more ship-berthing facilities than any other southeastern port and it is the leading foreign trade port between Baltimore and New Orleans. I emphasize this background because the Congress and the administration have repeatedly expressed a desire to upgrade the Nation's Merchant Marine. We want expanded programs and increased activities in our ports. It surely follows that along with this kind of expansion goes the need to provide necessary health care for the seamen who will be a part of this program.

I know that the need for budgetary restraints must also be considered but actions to close these facilities represent a lack of foresight. In fact, the cost of closing these hospitals and clinics may well exceed

the cost of improving and maintaining them because of patient transfers and increased costs of delivering health care elsewhere for the beneficiaries.

I think we have to do some hard and realistic thinking. We are all aware of the tremendous hospital shortage around the country. I know this is true in the Savannah area. The patient load cannot help but increase if the Public Health Service facilities are closed down and create an almost unbearable load on local institutions. I think the problem we face in my district is a good example. In addition to approximately 40,000 seamen in the area and personnel at the Army Flight Training Center at Hunter Field and Fort Stewart, there are more than 10,000 potential Government and military retirees. It doesn't take much imagination to realize what the impact of closing would be on these people. It would be devastating and hardly responsive to the great demand for these services.

Now that the Comptroller General of the United States, Elmer D. Statts, has ruled that the Department of HEW does not have the authority to close the U.S. Public Health Service facilities and, as Chairman Edward Garmatz of the House Committee on Merchant Marine and Fisheries has stated:

> This ruling is binding and conclusive on the executive branch of the Government . . . this decision should put an end to doubts and anxieties concerning the future of these invaluable health facilities. . . .

I hope the administration will do what it should have done in the first place and begin immediate plans to improve and expand the health services and facilities.

The bills we are presently considering, and which I have joined in cosponsoring, will certainly make clear the sense of the Congress on this matter. They plainly state that we not only want these facilities kept open, but that provision should be made for the upgrading and expansion of these units and services in order to make possible the best treatment and medical care for those entitled to these benefits. I strongly urge this committee to take the lead in seeing that the decision to close these facilities is reversed and to open up the way for better services for those who have earned them.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Hagan, the committee thanks you for being here today.

Mr. HAGAN. Mr. Chairman, thank you for affording me in the opportunity to be heard.

Mr. ROGERS. The Honorable Frank Annunzio of Illinois is our next witness. Welcome, Mr. Annunzio. Please proceed as you see fit, sir.

STATEMENT OF HON. FRANK ANNUNZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. ANNUNZIO. Mr. Chairman, I am pleased to be here today to offer my support for House congressional resolution 149. As a cosponsor of this resolution, I strongly believe in the purpose of this legislation.

The Public Health Service hospitals and outpatient facilities have a long and honored tradition of service to this Nation. Established by

an Act of Congress in 1798 to provide direct health care to sick and disabled American seamen, they have served this country well. Today, the Public Health Service also provides comprehensive health services to Coast Guard and military personnel and their dependents, to Federal employees with job-related illnesses and injuries, to commissioned Public Health Service personnel and their families, and to persons in need of emergency and temporary treatment. In addition, the Public Health Service recently was authorized to provide preventive medical care for urban and rural areas of this Nation which have inadequate health facilities and shortages of health personnel.

The scope of Public Health Service care is vast. During fiscal year 1969, Public Health Service hospitals admitted a total of 41,879 persons and had an average daily patient load of 2,232. Outpatient visits to the hospitals totaled more than 812,000 and represented medical care to more than 205,000 individuals. Visits to the 28 Public Health Service outpatient clinics totaled almost 800,000 and represented medical care to over 310,000 individuals.

In light of these impressive figures and the services they represent, how can the Department of Health, Education, and Welfare consider closing these facilities?

Mr. Chairman, we are in the midst of what the President, in his health message to Congress last week, termed a "deepening crisis in health." Critical shortages of health personnel and services exist in many parts of our Nation. This is not a time to close these facilities. Instead, we should broaden and expand them.

The Public Health Service Act gives the Surgeon General the authority to control, manage, and operate Public Health Service hospitals, institutions, or stations, and to provide for the care, treatment, and hospitalization of patients. Does the Surgeon General, however, have the authority to close these facilities?

The distinguished Chairman of the House Committee on Merchant Marine and Fisheries, Mr. Garmatz, recently asked Elmer Staats the Comptroller General of the United States, to give his views on an opinion rendered by the General Counsel of the Department of Health, Education, and Welfare. The General Counsel's opinion was that HEW had the authority to close the Public Health Service facilities.

In his reply to Mr. Garmatz, Mr. Staats, in a comprehensive eight-page letter, referred to a decision made by his predecessor, Mr. Joseph Campbell. In 1965, Mr. Campbell held that the closing of all Public Health Service general hospitals was beyond the discretionary authority of the Department of Health, Education, and Welfare. To be precise, Mr. Campbell wrote:

> . . . In the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to out-patient clinics one or more of the Services general hospitals. The closing, however, of all PHS general hospitals, with the general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority.

Mr. Staats underscored this opinion in his letter, when he told Chairman Garmatz:

> We find nothing in the HEW memorandum that would persuade us to reach a contrary view at this time.

At this point, I would like to commend the distinguished chairman of the House Committee on Merchant Marine and Fisheries for his active leadership in this serious matter. By requesting Mr. Staats to render his opinion, Chairman Garmatz has done an immeasurable service to this Nation.

Mr. Chairman, we in Chicago had the misfortune to see our Public Health Service hospital facility close in 1965. Those living in Memphis shared this unhappy experience in the same year. The Public Health Service closed two more hospitals in 1969—in Detroit and Savannah. Now we are faced with the possible closing of eight more Public Health Service general hospitals—in Baltimore, in New Orleans, in San Francisco, in Seattle, in Boston, in Galveston, in Norfolk, in Staten Island.

We must not allow this to happen. I offer my strong support for House Concurrent Resolution 149, for it is certainly the intent of Congress that these facilities remain open to continue to serve our Nation as they have done so ably for the past 173 years.

Mr. ROGERS. Thank you, Mr. Annunzio, for a fine statement. The committee appreciates your appearance here today.

Mr. ANNUNZIO. It has been my pleasure, Mr. Chairman. Thank you, sir.

Mr. ROGERS. Next we shall hear from our colleague from the State of North Carolina, the Honorable Walter B. Jones.

STATEMENT OF HON. WALTER B. JONES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. JONES. Mr. Chairman and members of the committee: I appreciate the opportunity to join with others in asking your approval of the resolutions which have been introduced on the continuation of the Public Health hospitals and outpatient clinics throughout this Nation.

I am not privileged to have one of these facilities located in my congressional district, but I am fortunate in having a large number of merchant marine seamen, both active and retired, as well as members of the Coast Guard, all of whom are living in close proximity to the Public Health hospital located in Norfolk, Va., which is most conveniently located and provides a vital and much needed service to those I have previously mentioned.

At a time when the caseload for medical needs of an increasing number of veterans is taxing the facilities of the VA hospitals throughout this Nation almost beyond their capacity, it certainly seems ill-advised and most untimely to even consider the closing of the Public Health hospitals and outpatient clinics. I am sure that the majority of this Nation feel a moral obligation to do all possible in the area of medical care for our ex-servicemen as well as the merchant marine seamen in appreciation for the patriotic services they have rendered.

I respectfully ask that your committee approve one of the resolutions which will be a statute requiring the continuing operation of these medical facilities.

Finally, rather than entertaining any idea of curtailing the services, I think it is incumbent on all of us to do everything possible to improve the services and to modernize and expand the present facilities.

Thank you for permitting me to express my strong feelings and include them as a part of your record.

Mr. ROGERS. Thank you, Mr. Jones, for a fine statement.

Mr. JONES. Thank you, again, Mr. Chairman.

Mr. ROGERS. The last of our congressional witnesses this morning is the Honorable Glenn M. Anderson of California. Welcome, sir. Please proceed as you see fit.

STATEMENT OF HON. GLENN M. ANDERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. ANDERSON. Mr. Chairman, I am appalled at any suggestion to close down a hospital program, especially at a time when the health care service in the United States is at a critical low. Such proposals are incongruous in light of the increasing workloads which hospitals and clinics are bearing, the ever-escalating costs for doctors, drugs, and hospital care, and the critical need for such services in many areas. There is a dearth of hospitals in this country.

Instead of curtailing services, every effort should be made to augment and expand health services and take positive steps toward providing meaningful, comprehensive, and professional health care for all citizens.

I protest the plans to close any of the existing Public Health Service hospitals or clinics. The PHS hospital system was established in 1798 as a means to provide medical care for merchant seamen. This system not only provides medical care for seamen, but it protects our Nation against disease castastrophes. Further, it has introduced and maintained a Public Health Service concept that benefits the medical profession, our Nation, as well as the seamen and other recipients of such hospital and medical care. The proposal to terminate this public service concept of medical care is shocking.

It is even more incomprehensible when we consider the total service, which the Public Health Service hospitals provide. At one time, there were 30 PHS hospitals. Today, there are eight along with 30 PHS clinics, one of which is located in my District in San Pedro, Calif. These facilities provide care to merchant seamen, to Coast Guardsmen and their dependents, as well as to active and retired military personnel and their families.

The contributions which these hospitals make are truly of great magnitude. Each facility is an integral part of the health care system of the community in which it exists and is helping to meet the rising demand for good health care. It serves as part of the training forum for badly needed medical personnel. There are 500,000 beneficiaries of the PHS program. In short, the PHS hospital system provides much needed service and should be expaned—not eroded.

For example, in the PHS clinic in San Pedro, Calif., in a 3-month period (July–October, fiscal year 1970), there were 26,777 outpatient visits. This workload average, of over 8,500 outpatient visits a month, was handled by a staff of 54 people.

Mr. Chairman, I would like to submit for the record, at this point, three tables which give an accurate picture of what just one PHS clinic, the clinic at San Pedro, Calif., is doing. Table I lists the total outpatient visits and number of different individuals visiting the San Pedro, Calif., outpatient clinic by class of beneficiary. Table II outlines visits to outpatient services as well as adjunct services and selected procedures. Table III gives us a picture of the heavy laboratory workloads handled by the San Pedro clinic.

(Tables I, II, and III follow:)

TABLE I.—TOTAL OUTPATIENT VISITS AND NUMBER OF DIFFERENT INDIVIDUALS VISITING THE SAN PEDRO, CALIF., OUTPATIENT CLINIC—BY CLASS OF BENEFICIARY, FISCAL YEARS 1965–69

Class of beneficiary	Fiscal year 1965		Fiscal year 1966		Fiscal year 1967		Fiscal year 1968		Fiscal year 1969	
	Total	Individual	Total	Individual	Total	Individual	Total	Individual	Total	Individual
All beneficiaries, total	61,184	26,334	70,816	25,474	84,048	29,023	84,527	32,851	82,803	33,083
Nonreimbursable, total	60,454	25,814	70,020	24,852	83,240	28,276	84,024	32,450	80,000	31,258
American seamen	27,625	5,206	34,022	5,180	40,581	6,583	42,087	7,840	41,814	8,266
BEC	1,468	207	1,519	198	1,977	255	2,031	311	1,570	437
ESSA (formerly C. & G.S.)	18	4	10	4	12	3	32	14	48	9
Coast Guard	9,150	5,151	10,544	5,121	12,789	5,928	10,848	7,482	10,243	6,814
Department of Defense	1,198	272	1,195	210	1,592	316	1,787	379	1,325	288
Department—OOD	1,975	597	3,654	717	6,144	1,054	6,853	1,244	6,154	1,126
Dep.—CG, ESSA, and PHS	4,425	969	5,355	894	5,247	851	4,597	1,025	3,977	989
Emergency	15	13	11	11	17	17	4	4	3	3
Federal employees (physical examinations)	394	280	511	413	354	302	359	298	191	139
PHS commissioned officers	490	182	632	261	640	300	718	208	507	116
Special study	21	1	57	5	261	76	291	248	299	162
Patients with leprosy	76	4	322	123	940	230	929	174	586	148
Inoculations and vaccinations	9,667	9,667	6,164	6,164	6,307	6,307	5,465	5,465	5,573	5,567
PHS field employees [1]	388	26	281	32	298	17	129	28		
Other	3,544	3,235	5,743	5,519	6,081	6,037	7,894	7,730	7,710	7,194
Reimbursable, total	730	520	796	622	808	747	503	401	2,803	1,825
Foreign seamen	41	10	140	25	62	15	124	58	60	20
Immigration and Naturalization			3	3	5	5			6	6
Emergency									2	2
Other	689	510	653	594	741	727	379	343	2,735	1,797

[1] Public Law 90-174 effective Dec. 5, 1967, removed PHSFE from eligibility.

Source: Monthly report on outpatients and adjunct services, Form PHS-T408.

TABLE II.—USPHS OUTPATIENT CLINIC, SAN PEDRO, CALIF.

VISITS TO OUTPATIENT SERVICES

Service	Total visits, fiscal year—				
	1965	1966	1967	1968	1969
Allergy		978	2,591	3,178	
Dermatology	784	769	731	641	868
General	38,464	44,638	50,705	47,370	51,537
Leprosy		[1] 315	935	905	929
Medicine					2,822
Ophthalmology	1,159	1,110	1,060	1,250	1,243
Orthopadics	359	377	410	669	577
Otolaryngology	730	1,167	1,006	929	847
Pediatrics		253	702	491	
Psychiatry	177	147	165	165	129
Pulmonary			[2] 64	396	486
Danlistry	7,592	7,239	7,617	8,170	7,473

ADJUNCT SERVICES AND SELECTED PROCEDURES

Services and procadures	Total number, fiscal year—				
	1965	1966	1967	1968	1969
Physical medicine—total visits: Physical tharapy (with qualified tharapist)	10,187	11,699	13,508	14,445	13,352
Radiology:					
X-ray examinations—total visits	9,963	12,645	10,275	9,633	8,123
X-ray films takan	16,256	21,153	21,008	21,688	18,747
Pharmacy:					
Prescriptions and requisitions	31,563	35,925	45,954	50,705	52,184
Total issues	6,892	7,439	5,960	7,329	5,869
Bulk compoundad items	168	183	96	370	214
Prepackaged items	16,701	20,243	32,222	32,870	30,089
Social service:					
New and reopenad casas	2,620	2,644	2,958	2,946	[4] 851
Case work interviews	5,193	5,234	6,110	6,076	[4] 2,775
Cases closed	2,601	2,633	2,999	3,047	[4] 703
Averaga monthly caseload per social worker	[3]	[3]	[3]	[3]	46
Operations in oparating room	2,165	2,085	2,163	2,060	1,898
BMR tests	2	1			
Electrocardiograms	1,217	1,490	2,168	[5] (1,826)	[5] (1,692)

[1] Data are for 6 months; began operating January 1966.
[2] Data ara for 4 months.
[3] Not available; caseload is not reportad on same basis as other stations.
[4] Data are for 10 months; social worker attanded conference and was on leave during August and September. Decline is due to mathod of counting caseload.
[5] Tests are reported on clinical laboratory table as part of miscellaneous catagory.

Sources: Monthly Raport On Outpatients and Adjunct Servicas, Form PHS-T408, Pharmacy Operations—Quarterly Raport, Form HSM-169-1, Social Service Monthly Statistical Raport, Form HSM-38 and Monthly Report Of Dental Operations And Administration, Form HSM-136-3.

TABLE III.—U.S. PUBLIC HEALTH SERVICE OUTPATIENT CLINIC, SAN PEDRO, CALIF.—LABORATORY WORKLOADS, FISCAL YEARS 1967-69

Department and fiscal year	Outpatients tests	
	Unweighted	Weighted
Total:		
1967	35,924	75,385
1968	34,666	68,817
1969	34,850	71,533
Chemistry:		
1967	4,768	13,882
1968	4,788	13,467
1969	6,186	17,600
Urinalysis:		
1967	6,962	13,351
1968	6,764	13,086
1969	5,881	11,321
Radioisotope:		
1967		
1968		
1969	4	8
Hematology:		
1967	13,000	19,446
1968	13,035	18,796
1969	13,051	18,605
Microbiology:		
1967	651	1,702
1968	975	2,563
1969	807	2,145
Parasitology:		
1967	370	1,114
1968	225	729
1969	250	777
Virology:		
1967		
1968		
1969	1	3
Serology:		
1967	6,257	6,875
1968	5,916	5,918
1969	5,545	5,842
Blood bank:		
1967	985	2,955
1968	644	1,932
1969	652	1,956
Histopathology:		
1967	763	3,052
1968	794	3,176
1969	781	3,124
Miscellaneous:		
1967	2,168	13,008
1968	1,525	9,150
1969	1,692	10,152

Source: Interagency clinical laboratory workload reporting system, HSM-164-1-164-10.

Mr. ANDERSON. I would also like to submit for the record, at this point, a letter from Mr. John J. Royal, secretary-treasurer, Fishermen and Allied Workers' Union, Local 33, I.L.W.U. Mr. Royal states that his ". . . organization vehemently opposes such a move . . ." and explains in his letter some of the advantages of maintaining and expanding the PHS hospitals and clinics.

(The letter referred to follows:)

FISHERMEN & ALLIED WORKERS' UNION, LOCAL 33 I.L.W.U.,
San Diego, Calif., January 8, 1971.

Hon. GLENN ANDERSON,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ANDERSON: We compliment you for taking the initiative in opposing President Nixon's proposal to close down the United States Public Health Outpatient Clinic in San Pedro, California.

Our organization vehemently opposes such a move, and we would appreciate your continued support on this matter.

As you know, this San Pedro U.S. Public Health Outpatient medical facility is the only one available to our seamen and commercial fishermen in the Los Angeles area. It provides irreplaceable and incomparable health services in the form of preventive medicine besides its normal health care; it provides dental and eye care also which are both available to our fishermen. It is, moreover, centrally located in the area of the Port of Los Angeles, and is conveniently placed among the homes and residences of our men who ply the high seas all year long.

U.S. Public Health care for the seafarer is a matter of simple social justice in the light of the unique relation he holds to his vessel, which is one of personal indenture; the dispensation or the distribution of health care to the seafarer by its "ward," the Federal Government, is based upon the historical tenets of necessity in order to protect him from being overreached by masters and shipowners. We do not want to lose this principle of "wardship."

The beneficent attitude of our country and its people toward our seafarers was ably put by Justice Story when he set forth the underlying principles impelling the nation to that attitude. These were: (1) The protection of seamen who, as a class, are considered improvident from the hazards of illness and

abandonment while ill; (2) The inducement to masters and owners to protect health and safety of seamen while in the merchant service; (3) The maintenance of a merchant marine and a fishing fleet for the furtherance of foreign trade in time of peace and as an arm of defense in time of war; and (4) By inducing seamen to accept employment in an arduous and perilous service. Every maritime nation has underwritten the health and welfare of its seafarers in this humanitarian and protective spirit. In fact, our nation from its earliest period of national existence has faithfully recognized the value of its men of the sea and their calling in this social context.

The U.S. Public Health Outpatient Clinic in the Port of Los Angeles, San Pedro, California has made in the past, and is still making a benevolent, humane and vital contribution to the health and welfare of our seafarers and fishermen in the whole Los Angeles complex. We hope that it will be allowed to continue. It makes seafaring and fishing not only a socially useful calling but also a safe one!

May we, therefore, respectfully urge you to continue to fight, in your forthright fashion, for this vital and meaningful social service.

Respectfully yours,

JOHN J. ROYAL, *Secretary-Treasurer.*

Mr. ANDERSON. I have mentioned the need to expand our PHS facilities. Congress overwhelmingly passed the Emergency Health Personnel Act of 1971 which was signed into law by the President last New Year's Eve. Under this act, the role of the Public Health Service is expanded beyond its present beneficiary group to help meet health needs in urban and rural poverty areas. Why would the administration approve a law to expand services, and, then, with the other hand, advocate the closing of the hospitals and the clinics?

To rely on the Veterans' Administration hospitals to take over the PHS caseload, as suggested by Secretary Richardson, appears not to be properly accounting for the already overburdened condition of these facilities. The VA cannot handle U.S. Public Health Service beneficiaries in addition to the VA's own patients.

Mr. Chairman, as a supporter and cosponsor of the House concurrent resolutions now under consideration by your distinguished committee in the manner of these hearings; as a member of the House Merchant Marine and Fisheries Committee which has conducted hearings on this matter; as a person concerned with the escalating costs for doctors, drugs, and hospital care that now cost Americans some $70 billion a year (a 16-percent rise last year, far greater than our general inflationary trend in the United States); as an American concerned about the poor state of the Nation's health, despite the fact that we have in our highly industrialized and technological society the ability to provide proper medical care for our people; I support the resolutions being considered today and appeal to all concerned persons to help in our efforts to expand and modernize our existing health care facilities and not erode or eliminate the PHS.

I urge that all efforts be made toward building, and not destroying, the Public Health Service hospital system.

Mr. ROGERS. Thank you, Mr. Anderson, for your very thoughtful statement and for the attachments to your statement. I am certain they will be of help in the diberations of the committee.

Mr. ANDERSON. Thank you, Mr. Chairman, for your kind considerations.

Mr. ROGERS. I see one of our colleagues from the full committee, Congressman Brock Adams is here. He has testified.

But I think you have a witness to introduce.

Mr. ADAMS. Yes, Mr. Chairman. If I could, I would like to introduce the witness this morning.

Mr. Chairman, I appreciate very much the committee taking the time to hear the dean of the University of Washington Medical School. And I want to echo the words of Congressman Fascell that action will be taken by the Congress. I think the colloquy between the chairman and Mr. Fascell was very accurate as to the situation.

I wanted to take this opportunity to report to the committee. When I testified on Tuesday of the week I indicated we had asked that the director of the hospital in Seattle, Dr. Willard Johnson, testify. On March 4, I telegraphed Secretary Richardson to request that Dr. Johnson, the administrator of the hospital, be allowed to testify. On March 10, we were advised by Dr. Glen Wegner, the Deputy Assistant Secretary of HEW, that the Secretary had denied our request. I regret that. It seems to me that we should have this important testimony. I have previously testified that the hearings in Seattle were not in any way complete or full hearings and I did not want the committee to believe that they were.

Today I want to introduce the dean of the University of Washington Medical School. In my testimony earlier I indicated the relationship between the university and the hospital. I think that you will find that Dean Van Citters is very well qualified both to discuss the hospital and the problems of contracting over either to the University of Washington or to a community service.

So, Mr. Chairman, I would like to introduce Dean Van Citters of the University of Washington School of Medicine.

With the committee's indulgence, I will go downstairs to my Transportation Subcommittee while you continue your hearings on health problems.

Mr. ROGERS. Thank you very much, Congressman Adams.

And Dean Van Citters, we welcome you. And we appreciate your being here to give us the benefit of your testimony.

STATEMENT OF DR. ROBERT L. VAN CITTERS, DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF WASHINGTON, SEATTLE, WASH.

Dr. VAN CITTERS. Thank you, Mr. Chairman.

Thank you, Mr. Adams.

I am Dr. Robert L. Van Citters, dean of the School of Medicine at the University of Washington, Seattle. I would like to enter for the record a formal statement which we have prepared, and also a background paper which contains statistics of the operation of the hospital and so forth.

Mr. ROGERS. Without objection it will be made a part of the record.

Dr. VAN CITTERS. My comments this morning will merely summarize what is in these documents.

My concern in these hearings relates to the impact which the closing of this hospital would have on medical education, and particularly on our efforts to provide health manpower for the Pacific Northwest.

By way of background, we are the only graduate school of medicine between Minneapolis and the Pacific Ocean. We are a major source of health manpower for the area which includes Washington, Idaho, Montana, and Alaska.

We supply many of the trained health professionals for that four-State area.

The U.S. Public Health Service Hospital in Seattle is an integral part of our health sciences center.

We are, then, a regional health center, a regional referral center and a regional facility. We operate a health sciences center. We have schools of medicine, dentistry, nursing, pharmacy, public health, and social sciences. We function together with a common facility and faculty. We are currently training, approximately, in round numbers, 400 doctors, 750 nurses, 300 dentists, 100 interns, and 300 residents. And we have about 28 programs for training paramedical personnel and physician assistants of various types, totaling about 2,000 trainees.

We have increased our enrollment over the past 2 years. And we have scheduled a 50 percent increase in all of those health-related schools for 1972.

We are straining every effort to fill the health manpower needs of our State and our region.

In order to do this we need the raw material of medical education. And that of course includes laboratories, hospitals, faculty, facilities, and so forth.

The University Hospital at Seattle, at the University of Washington, is very small. In fact it is the smallest State operated university hospital in the country. And it is totally inadequate to handle the patient volume required for all of this training.

For this reason, then, we have established affiliations with many private and public institutions. This helps reduce our costs, and it also helps these institutions attract faculty and staff. It improves the quality of care.

Now, in that context we have for many years had a superb teaching affiliation with the USPH Hospital in Seattle. This affiliation is absolutely essential for our teaching program. To terminate it at this point would spell major disaster for our efforts to supply health manpower for our region.

A major part of our clinical training takes place in that hospital. The specific details are in the documents which I have introduced. I will summarize these briefly by saying that at any given time about one-third of our medical students in the clinical phase of their training will be in the wards of that hospital. Our internship and resident programs are both affiliated at the university; some 20 interns and 30 residents will be on the ward at the USPH Hospital, and 49 full-time faculty are permanently located at the USPH Hospital.

We also have about 20,000 square feet of research space, and about $1 million research program which is manned by several internationally famous researchers. I would point out one, the cancer research training facility, which has both hospital beds and laboratories, and is a unique facility. It is a national resource. There are no others like it.

Finally, I would point out that we are the recipients of a major grant from the USPH to increase our class size and to increase our facilities.

The closure of this hospital, then, would impede not only our ongoing efforts, but would give us the opportunity to increase our pro-

gram, because these increases, of course, are based on continued use of the hospital.

Now, we think that our health sciences center has developed a number of new and exciting programs to help improve the supply of health manpower in the northwest. I have already mentioned our increase in class size, our construction program to increase it further, and our many affiliations with other hospitals, so that we have avoided building a huge hospital complex.

We have streamlined our curriculum; we have shortened it, eliminating almost 1 full year.

And we have a physicians' assistance program, the MEDEX program, which is unique, I believe.

We have implemented a department of family medicine to provide family doctors for the rural areas in that five-State area.

And we have instituted a program for regionalizing our school.

Our ability to maintain all of these programs is contingent on continued operation of this hospital.

Now, we have had some discussions with the Department of Health Service and Mental Health Administration about arrangements which would transfer the management responsibility from the United States to the community. We believe that such an approach would probably not produce advantages to either the Federal Government or the university, and in particular if it is intended that this hospital is to remain open and operational for less than at least 5 years.

I will cite these four reasons:

One, this hospital is currently providing a high quality of care to beneficiaries at a very low operating cost. There would be no financial savings were this to be transferred.

Two, the facility would have to be brought up to date if it were to be operated by any organization other than the Federal Government, because it does not now comply with local and State codes for operation of a health facility.

Three, some special authorization would have to be negotiated to assume the continuity of the beneficiaries, in particular the secondary beneficiaries, the DOD component, which represents more than half of those patients.

And finally, there is no way that a university or a community organization can take over this hospital on a per diem basis; it would have to be a contractual arrangement, long term and lump sum.

In summary, I would point out that we think that the U.S. Public Health Hospital in Seattle is now very efficiently managed; it is delivering a high quality of care to a well-satisfied category of patients, and at a very low cost. And the hospital is making a substantial contribution to medical education. We intend to increase our commitment to medical education in the next year, and this hospital will be required.

We have hopes, therefore, that the Congress will provide assurances and resources to preserve this institution in Seattle for 4 or 5 years to allow us at the university sufficient time to develop alternate resources for training this health manpower.

(Dr. Robert Van Citters' prepared statement, together with accompanying "Status Report Relative to Possible Closure" follows:)

STATEMENT OF DR. ROBERT L. VAN CITTERS, DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF WASHINGTON, SEATTLE

I am Dr. Robert L. Van Citters, Dean of the School of Medicine at the University of Washington, Seattle, Washington. My concern at these hearings relates to the negative impact which closure of the U.S.P.H. Hospital will have on medical education and on our efforts to supply trained health professionals for the Pacific Northwest.

The School of Medicine at the University of Washington is the only school in the northern tier of states between Minneapolis and the Pacific Ocean. We are a major source of health manpower for the five state area including Washington, Alaska, Montana, Idaho, and Wyoming; although fundamentally a State funded school, we have accepted major responsibilities for training health professionals—not only physicians—but also nurses, dentists, physician's assistants, and paramedical personnel, for all of these states. Our Health Sciences Center, of which the U.S.P.H. Hospital in Seattle is an integral part, also serves as a referral center for the area, and our facilities and faculty have become recognized as a regional resource. In that sense, we have become regarded as a regional facility and in fact, have developed a program for regionalizing the School which has been accepted with enthusiasm in the states involved.

The Health Sciences Center at the University of Washington encompasses the Schools of Medicine, Dentistry, Nursing, Pharmacy, Public Health, and Social Sciences. All function together under a common administration, with common faculty and facilities. Our School currently has in training approximately 400 physicians, 750 nurses, 300 dentists, 100 interns, 300 residents, and has in addition over 28 other programs for training paramedical personnel and physician's assistants, totaling over 2,000 individuals. The School of Medicine has increased its enrollment by 25 percent over the past two years and we have scheduled a 50 percent increase in size of the classes of all of the Health related schools in 1972. We are straining every effort to fulfill the Health Manpower needs of our state and the region. In order to accomplish this, we need the raw materials of medical education—facilities, hospitals, laboratories, patients, faculty. The School of Medicine at the University of Washington has a very small hospital facility, indeed, it is the smallest of any hospital operated by a state medical school. It is totally inadequate to handle the patient volume required for our training programs. For this reason we have established teaching affiliations with many local clinics and hospitals, both public and private. This is to the advantage of the School in that it has reduced our costs and to the hospitals in that the academic affiliation has enabled them to attract distinguished staff and has elevated the standards of care. In this context, we have enjoyed a superb teaching affiliation with U.S.P.H. Hospital in Seattle for many years; this affiliation is absolutely essential to our teaching program; its termination would be a major disaster for our efforts to supply Health Manpower for the Pacific Northwest.

A major portion of the clinical training at the Health Sciences Center is carried out at the U.S.P.H. Hospital. The specific details, including description of these educational programs, numbers and types of students and patients involved, have been set forth in two position papers, dated 6 January 1971 and 14 January 1971, which were made available to the Committee earlier. I will only summarize these: at any given time nearly one-third of our clinical medical students are on duty at the U.S.P.H. Hospital. The Internship Program at the U.S.P.H. Hospital is totally integrated with the University so that at any given time twenty interns are on duty there. Similarly, the Residency training program, for developing medical specialists, is totally integrated with that at the University and at any given time, thirty young doctors are on the wards at U.S.P.H. Hospital in advanced stages of their training. At the present time 49 full time members of our faculty are permanently located at the U.S.P.H. Hospital; these faculty members serve both the educational needs of the University and the medical needs of the beneficiaries at the Hospital. The research program at the U.S.P.H. Hospital is funded at the level of about $1 million annually; included are several investigators who have acquired international research reputations. Specifically, the U.S.P.H. Hospital houses an unique cancer research and training facility which was largely funded by the NIH and has been operational less than two years.

It was in this facility that complete exchange of bone marrow was first successfully accomplished in management of patients with leukemia; the facility includes both hospital beds and laboratories for special treatment of patients with malignant diseases. This laboratory is unique in this country—it is a national resource. Finally, we are recipients of a major grant from NIH for construction of additional facilities which will enable substantial increases in class

size in all of our educational programs. In order to attract these funds, we committed ourselves to sequential increases in our class size over the next several years. These commitments were based on contiuuing operation of the U.S.P.H. Hospital as a major teaching facility, and this condition was stated in the contract nnder which the funds were obtained. Thns, closure of this hospital will not only impede our on-going teaching efforts, but will aiso endanger our ability to increase that effort. In effect, then, closure of the U.S.P.H. Hospital would negate the future of the programs we have developed to improve the supply of Health Manpower in the Pacific Northwest.

The Health Sciences Center at the University of Washington bas been a leader in the development of new programs to improve the delivery of Health care services in tbe Pacific Northwest. We anticipated the shortage of Health Manpower more than five years ago, and as a result, are now in the midst of a major construction program which will enable subsequent increases in class size. We have cut our costs by functioning as a Healtb Sciences Center, with common faculty and facilities for all the health professions. We have involved local pnblic and community hospitals in our teachiug effort rather than to build a huge bospital complex. We have increased our enrollment to the maximum nnmber which can be accommodated within our existing faciilities. We have streamlined our curricnlum and have shortened it by a full year. We have developed a Physician's Assistant Program to help practitioners deliver Health care. We have implemented a new Department of Family Medicine to provide physicians for tbe rural areas of our five state region which are in desperate need of medical care, and we have instituted a new concept, that of regionalizing the School to train Health professionals for the five state area. Our ability to maintain all of these edncational and research programs is dependent on continued operation of the U.S.P.H. Hospital.

We have had preliminary discussions with the Department of Healtb Service and Mental Health Administration abont an arrangement which would transfer management responsibility for this hospital to tbe community. We believe that sncb an approach would probably not produce advantages to either the Federal Government or the University of Washington, particnlarly if it is intended that the hospital remain in operation iess than five more years.

(1) The hospital provides high qnality care to the Federal beneficiaries at a very low operating cost. There wonld be thus, more financial savings under present management arrangements.

(2) Tbe facilities would probably need to be brought up to the standards of local bealth and safety.

(3) Special authorization would have to be provided to assume continuity of all beneficiaries including the Department and Government Independents.

(4) A contractnal arrangement would have to provide a long term, lump sum contractnal commitment in order to provide expected assnrances to tbe University's governing body.

In summary, I should like to point out that the U.S. Public Health Service Hospital in Seattle is now very efficiently managed. It currently delivers a high quality of care to a large and well satisfied patient profession at very low cost. The Hospital is now making a major contribution towards a training program for pbysicians and other intern manpower. Major enlargements of these programs will begin next year. The U.S. Public Service Health Hospital will be even more urgently needed after this enlargement. It is therefore, our bope that the Congress will provide assurances and resources to preserve this Institutiou in Seattle for the next four to five years, to allow the University of Washington sufficient time to develop equivalent alternate resources for training its medical and nursing students.

TRAINING

Affiliation Agreements

The University of Washington and the United States Public Health Service entered into an affiliation agreement witb the objective to "enhance tbe achievement of their respective teaching and research objectives as well as to insure provision of optimum patient care". This agreement, signed hy the Assistant Surgeon General, became effective July 1, 1966, and includes the following clause:

Annual Review and Termination Cause

This memorandum of understanding shall be reviewed annually and this agreement may be terminated no sooner than one year following this annual review *provided* such termiuation is requested by either party 90 days prior to the time of annual review.

Individual training programs covering internships and residencies have been formalized in documents and they are specifically based on this basic affiliation agreement. Thus, the earliest termination of the agreement would be July 1, 1972.

Seattle University has an affiliation agreement with the Public Health Service for their nursing education program. This agreement is dated June 11, 1969. The terms of agreement include "termination of this agreement will be by a request in writing from either party effected on September 1st provided the notification is received by the last day of September of the previous year."

Educational Programs

The Seattle Public Health Service Hospital has, by far, the largest University teaching involvement of any of the Public Health Service Hospitals in the nation. There are 49 physicians at the Hospital who are full members of the University faculty.

The number of educational programs at the Public Health Service Hospital has been increasing steadily, particularly since the development of a formal affiliation agreement in June of 1966, with the University of Washington. The programs include a total of 29 residencies in gynecology, medicine, neurology, ophthalmology, otolaryngology, rehabilitation medicine, surgery, pathology, and urology. There are departmental internships in medicine and surgery.

Approximately one-third of the medical students in the one year basic clinical clerkship are located at the Public Health Service Hospital. This amounts to approximately thirty students now and will be increased to approximately 40 students in 1972–73. In addition, a number of other clinical courses are conducted at the Public Health Service Hospital, and these are always in great demand by the medical students. The maximum number of medical students at the Public Health Service Hospital at any one time is approximately 75. Seattle University has their whole junior class of approximately 50 students at the Public Health Service Hospital and has increased their sophomore class size by approximately 10 percent this year which is based on using the Public Health Service Hospital.

The Public Health Service Hospital is of particular benefit to the University because of its broad base of beneficiaries and outpatients, both male and female. The patients available at the Veterans Administration Hospital are not comparable as to range and sex.

SUMMARY OF TEACHING INVOLVEMENT

	Number of programs	Maximum number of students at any given time	Average number of students at any given time
University of Washington:			
Medicine:			
Medical students	10	75	20
Interns	3	19	17
Residents	10	29	29
Total, medicine		123	66
Pharmacy:			
Undergraduate	1	3	2
Graduate	1	1	
Total, pharmacy		4	2
Dental: Graduate	2	5	4
Total, dental		5	4
Seattle University: Nursing	1	50	25
Total, nursing		50	25
Community colleges	5	10	5
Total, community colleges		10	5
College work study	1	5	
Highline community program	2	4	
Summer aides	1	12	1
Neighborhood youth program	1	5	
WIN program	1	3	
Job Corps, YWCA, Seattle	1	10	1
Job Corps, Tongue Point, Oreg.	1	12	1

PHS Hospital Staff With Major Teaching Involvement at University of Washington

MEDICINE AND RANK

Belding, Melvin, Instructor
(CO) Brewer, Gayle F., Instructor
Buckner, C. D., Asst. Prof.
Clift, Reginald A., Res. Assoc.
(CO) Dohner, V. A., Instructor
Espeland, D. H., Instructor
Fefer, A., Asst. Prof.
(CO) Funk, D. D., Asst. Prof.
(CO) Gaul, Louis, Cl. Instr.
(CO) Gotshall, R. A., Instructor
(CO) Griep, Robert, Asst. Prof.
Gutman, Laura, Res. Inst.
(CO) Holmes, K. K., Asst. Prof.
(CO) Johnson, W. P., Assoc. Prof.
Klebanoff, S. J., Prof.

MICROBIOLOGY

(CO) Brancato, Frank P., Asst. Prof. (Affil.)

OBSTETRICS-GYNECOLOGY

(CO) Child, David L., Instructor
(CS) Smith, Donald C., Asst. Prof.

OPHTHALMOLOGY

(CS) Kramar, Prloska O., Instructor

ORTHOPEDICS

(CO) Madenwald, Malcom, Instructor

OTOLARYNGOLOGY

(CO) Caln, Alvin L., Instructor
(CO) Morrison, Winsor C., Instructor

PATHOLOGY

(CO) Hall, Eugene, Asst. Prof.

PM&R

(CS) Snow, Willard, Instructor
(CS) Stanwood, John E., Instructor
Stolov, Walter C., Professor
(CS) Loescher, R. A., Instructor
(CO) McDonough, J. R., Asst. Prof.
(CS) Neiman, P. E., Asst. Prof (4/71)
Paulsen, C. A., Professor
Rudolph, R. H., Asst. Prof.
(CO) Santen, Richard, Instructor
(CO) Shimoda, Stanley S., Asst. Prof.
Simpson, David P., Assoc. Prof.
(CO) Sinaly, Nicholas, Asst. Prof.
Slichter, Sherrill J., Instructor
Storb, Rainer F., Asst. Prof.
Thomas, E. Donnall, Professor
(CS) Turek, Marvin, Assoc. Prof.
(CO) Wills, Robert E., Instructor

PHYSIOLOGY AND BIOPHYSICS

(CO) VanHassel, Henry J., Asst. Prof.

SURGERY

(CO) Allen, Charles D., Instructor
(CO) Sikkema, Wesley, Asst. Prof.

UROLOGY

(CO) Mouda, George D., Instructor

DENTISTRY—ENDODONTICS

(CO) Crump, M. C., Asst. Prof.
(CO) VanHassel, H. J., Asst. Prof. (see Phys. & Biophys.)

ORAL SURGERY

(CO) Folsom, T. C., Asst. Prof.

PERIODONTICS

(CO) Levine, Sheppard, Asst. Prof.

PROSTHODONTICS

(CO) Smith, Dale E., Asst. Prof.

RESEARCH AND SPECIAL PROGRAMS

Oncology

The Division of Oncology of the University of Washington is based at the U.S. Public Health Service Hospital in Seattle because of the affiliation of this institution with the University.

The Division of Oncology utilizes one-half of the tenth floor and one half of the 7th floor of the hospital. The division employs 56 individuals including 14 physicians, all of whom work at the U.S. Public Health Service Hospital.

The following is a list of the funds available to the division and their sources:

CA 10895 "Adult Leukemia Research Center" 11/1/70-10/31/71 $423,197; 6/1/68-8/31/73 $2,102,323. National Cancer Institute, NIH.

CA 10167 "Separation of blood by continuous flow centrifuge" 1/1/70-12/31/70 $67,926: 1/1/70-12/31/74 $226,857. National Cancer Institute, NIH.

CA 05231 "Oncology Training Program" 7/1/70-6/30/71 $77,392: 7/1/70-6/30/73 $270,880. National Cancer Institute, NIH.

CA 10777 "Immunologic aspects of autochthonous tumor regression" 9/1/70–8/31/71 $23,392; 9/1/68–6/30/71 $64,981. National Cancer Institute, NIH.
CA 11438 "Normal and abnormal bone marrow metabolism" 1/1/70–12/31/70 $43,068: 1/1/70–12/31/72 $131,591. National Cancer Institute, NIH.
AI 09419 "Irradiation and marrow transplantation in large animals" 10/1/70–9/30/71 $80,639" 10/1/69–9/30/74 $440,439. National Institute of Allergy & Infectious Diseases
PH 43–67–1435 "Evaluation of typing techniques in clinical homotransplantation" 7/1/70–12/31/71 $134,150 (contract). National Institute of Allergy & Infectious Diseases, NIH.
T–280 "An investigation of the role of isogeneic and allogeneic marrow in the therapy of cancer" 3/1/70–2/28/71 $19,695. American Cancer Society.
Platelet preservation contract—"Preparation of Platelet concentrates" 7/1/70–6/30/70 $51,857. National Health and Lung Institute, NIH.
"Institutional Cancer Grants at $3,000 each." Rainer Storb, M.D., Paul E. Neiman, M.D. and Leroy Fass, M.D.

U.S.P.H.S.—(salary for 1 physician)	$21,300
American Cancer Society—(stipend for 1 Fellow)	4,800
Leukemia Society—Special Fellowship	10,000
State funds	27,000
Partnership	7,200
Funds donated by patients	5,000

Total spent during one year is approximately 1 million dollars.
In addition, the following grant and contract will be funded in 1970.
Pending: "Immunotherapy of canine lymphosarcoma" 1/1/71–12/31/71 $139,291 (contract).
"Platelet Center for Cancer Patients" 9/1/70–9/1/75 $478,562.

Specific Activities of the Division of Oncology

1. *Clinical Cancer Center.* The Adult Leukemia Research Center was established at the U.S. Public Health Service Hospital in 1969 and is funded by the National Cancer Institute. This unit was established at the request of the NCI in order to have a facility to serve the Pacific Northwest including Alaska. The total award for this project was for over $2 million to run from 1968 through 1973. One-half of the 7th floor (2,700 square feet) was remodeled and equipped at a cost of $200,000 in 1968–1969. The 8 bed units include 2 laminar air flow rooms which cost over $25,000 each to install.

From July 1969 to July 1970, 152 patients were admitted to the research unit. A Total of 1,895 patients days were accumulated. In addition, there were 494 outpatient visits to the ward.

The unit is engaged in studies of bone marrow transplantation, high dose chemotherapy and immunotherapy in patients with malignant disease. The research that is carried out involves the intensive care of patients and require special facilities for supportive care such as laminar air flow rooms and facilities for platelet and granulocyte procurement.

2. *Histocompatibility typing.* The unit operates a histocompatibility typing laboratory located on the 10th floor of the U.S. Public Health Service Hospital which is utilized by physicians in the Northwest. This facility performs lymphocyte typing and mixed leukocyte testing on potential human marrow and organ transplant patients and donors. In a 12 month period 313 donors and 118 recipients were typed in this lab.

3. *Laboratory Research Activities.*—The 10th and 11th floors of the U.S. Public Health Service Hospital (678 square feet) contain the laboratories and animal facilities of the Division of Oncology. The activities of the division include research concerning bone marrow transplantation in animals and man, histocompatibility typing, white cell procurement and transfusion, bone marrow preservation, RNA metabolism and immunotherapy.

A total of 53 publications show the scientific accomplishments of the division since work began at the U.S. Public Health Service Hospital in 1963.

The clinical activities of the division include staffing the Oncology clinics at the U.S. Public Health Service Hospital and University Hospitals and consultation.

Members of the division serve as consultants in oncology for all the University affiliated hospitals, private hospitals in Seattle and suburbs and are available and utilized for consultation by physicians throughout the Northwest including Alaska.

A varied teaching program is carried out by the division. Four post-residency fellows are in the training program each year. Medical student teaching of oncology is carried out by the staff at the University of Washington and the U.S. Public Health Service Hospital. In conjuction with the Regional Medical Program a preceptorship in oncology for practicing physicians has been established at the U.S. Public Health Service Hospital. All members of the division serve as attending on the general medical wards of the U.S. Public Health Service Hospital.

Endocrinology and Reproductive Physiology

Dr. C. Alvin Paulsen has established a research laboratory in Endocrinology and Reproductive Physiology. The major interest of his group consists of a study of human male and female reproductive physiology and pathology. The information generated from these studies is of great importance in understanding the mechanisms involved in reproduction and will clearly be of great value in developing suitable means of population control. Currently, primary compounds are being evaluated for their effectiveness as contraceptives for the male. In addition the information obtained from the studies has proved invaluable in treatment of infertile males and females and has helped to establish the genetic causes of infertility.

Research Training Unit

Under the direction of Dr. Seymour J. Klebanoff, a Research Training Unit was established several years ago with the aid of a training grant from the National Institute of Arthritis and Metabolic Diseases (NIAMD). This unit assists in the research training of individuals who desire a career in academic medicine. The approach is interdisciplinary and emphasizes the application of the advances in the basic sciences to clinical problems. The current grant period is from July 1969 through June 1974 and is funded for $817,026. Dr. Klebanoff's major research interest deals with the host defense mechanisms against bacterial, fungal and viral agents with particular emphasis on the microbicidal mechanisms in leukocytes.

Cooperative Study Programs

The U.S. Public Health Service Cooperative Study is an association of clinical investigators in seven USPHS Hospitals engaged in continuing research in hypertension and renal disease. The hospitals are located in Baltimore, Maryland; Boston, Massachusetts; New Orleans, Louisiana; Norfolk, Virginia; San Francisco, California; Seattle, Washington; and Staten Island, New York. The Study Group, initiated in September 1959, first began investigation into the evaluation of various drug combinations in the therapy of hypertension. The renal disease study is in its seventh year and the hypertension study is in its fifth year. It is anticipated that these studies will continue another five years.

Infectious Disease Laboratory

An infectious disease laboratory, under the direction of Dr. Marvin Turck, serves as a central referral center for patients with urinary tract infections. This is the only laboratory in the Pacific Northwest available to perform serological identification of coliforms to differentiate reinfection from relapsing urinary tract infections. These studies have been responsible for guiding the optimal types and durations of treatment of patients with recurrent urinary tract infections.

Other Research

Other research programs have been established in cardiology, gastroenterology, nephrology, special hematology, pulmonary function, nuclear medicine, pyelonephritis, pathology and dentistry.

Approximately 100 people, paid by other than PHS Hospital funds, are employed on the above programs as investigators, technical, clerical and laboratory assistant personnel.

Rehabilitation Medicine

The PHS Hospital has established a fully integrated physical medical and rehabilitation service for patients with major and minor neuromuscular and musculoskeletal disabilities as well as in disabling conditions growing out of general medical and surgical problems. In addition to physical and occupational therapy, services include speech therapy, clinical psychology and medical social service case work. The affiliation with the University of Washington also pro-

vides, as necessary, driver training for the handicapped, extensive vocational rehabilitation where appropriate, and highly customized orthotic and prosthetic work.

COMMUNITY ACTIVITIES

Kinatechitapi Clinic

The Kinatechitapi (Indian) Clinic is held three nights a week at the U.S. Public Health Service Hospital. This is a non-profit organization of primarily urban American Indians dedicated to the betterment of this large and oft neglected minority group in our community.

The clinic is staffed by physicians, nurses and paramedical personnel purely on a voluntary basis, many of whom are active duty Public Health Service Officers. The patient care, diagnosis, treatment-referral is accomplished free of charge to the recipients and indeed, this a flagrant void in the community. It is the only clinic of its kind which operates at a hospital using much of its facilities on a promissory basis. It has been in operation for approximately one year and has achieved renown worthy of emulation in the community by providing care for thousands of medically under-privileged Indians.

The U.S. Public Health Service Hospital is proud to be able to assist in this vitally needed community service which is above and beyond its legally delegated function.

STATEMENT BY THE HONORABLE ELLIOT L. RICHARDSON, BEFORE THE HOUSE MERCHANT MARINE AND FISHERIES COMMITTEE, DECEMBER 30, 1970

Mr. Chairman and Members of the Committee: I appear before you this morning to discuss recent reports and statements concerning the future of the PHS Hospital and Clinic system.

The Department of HEW has been considering the possibility of closing the 8 general hospitals and 30 outpatient clinics. These deliberations specifically do not include the Clinical Research Centers at Ft. Worth and Lexington and the Leprosarium in Carville, Louisiana. I wish to stress the fact that no decision has been made at this time on the institutions which are under study. The current review is based on two primary considerations. The first and the most important of these is our inability to continue to provide medical care of high quality to primary beneficiaries through an increasingly inefficient and outmoded system. The second is the cost involved in (a) operating the present program, and (b) in modernizing or replacing the existing physical facilities. These considerations are under review at a time when the total Federal budget is under severe stress.

The majority of the PHS facilities are underutilized, are becoming increasingly inefficient in terms of health manpower utilization as well as dollars, have difficulty in attracting and retaining career professional staff, and in some cases are unable to provide the range of services expected in an acute short-term general hospital. The inadequacy of the physical plants has been fully documented, and it is estimated that modernization or replacement would require at least $140 million at Fiscal Year 1971 prices.

In all of these discussions it has been emphasized that the Department of HEW would retain primary responsibility for the support of medical care in behalf of its beneficiaries. This will not be delegated to any other public or private agency. However, it has been proposed that the Department enter into agreements or contractual arrangements through which care would be provided by another agency. In our discussions with the VA they have expressed an interest in expanding the present arrangement with HEW. The proposed expansion would provide care for additional primary beneficiaries of HEW *on a space available basis with no modification in present VA beneficiary priorities.* In those locations or situations where the VA could not serve the patients' needs, *HEW would utilize non-Federal contract resources.*

If the hospitals and clinics were to be closed and arrangements with the VA and non-Federal resources consummated, it is the professional opinion of my staff that this will provide high quality comprehensive medical services. Furthermore, the services would be more accessible to the beneficiaries and be provided in more modern physical facilities.

The VA, with 162 hospitals as compared to the 8 PHS hospitals, has economies of scale which makes it seem likely that they could provide care to our beneficiaries at a substantially lower cost. Our conversations with the VA and a study of their annual reports indicate that it is reasonable to assume that many if not all of the primary beneficiaries could be cared for in VA facilities. The VA is conducting a study on bed capacity whose results should be available shortly, and we will be examining the accuracy of our assumptions with the VA staff.

Our review of the PHS facilities will include discussions with involved communities to explore potential conversion to other health functions. For example, such a facility might be utilized as the base for a Health Maintenance Organization serving the surrounding area. Others might be converted into intermediate or long-term care facilities, nursing homes, health manpower training facilities or research laboratories.

I wish to repeat that no final decision has been made. The future of the PHS hospital and clinic system is under intense review. We are prepared to share with the committee and the Congress the information and factors which are entering into our deliberations. Members of my staff are prepared to meet with you and discuss your suggestions, concerns, and any additional information which you may wish to provide. Before a final decision is made, we will review our findings with the Congress, beneficiary groups, and employee organizations.

Thank you, Mr. Chairman, and I will be pleased to answer any Committee questions.

Status Report Relative to Possible Closure—U.S. Public Health Service Hospital, Seattle, Washington

INTRODUCTION

In a Statement before the House Merchant Marine and Fisheries Committee on December 30, 1970, Secretary of Health, Education and Welfare Elliot L. Richardson stated that "The Department of HEW has been considering the possibility of closing the eight general hospitals and thirty outpatient clinics." He further stated that "No final decision has been made. The future of the PHS Hospital and Clinic System is under intense review . . . Before a final decision is made, we will review our findings with the Congress, Beneficiary Groups, and Employee Organizations". A copy of Mr. Richardson's statement is appended.

In furtherance of this review, a site visit by members of the staff of the Health Services and Mental Health Administration (HSMHA) of HEW will be conducted at the Seattle PHS Hospital on Monday and Tuesday, January 18 and 19, 1971. The HSMHA Representatives will meet with five interested groups: (1) Federal Agencies, (2) Community Representatives, (3) Educational and Training Organizations, (4) Beneficiary Groups and (5) PHS Hospital Staff.

A brief summary of the hospital mission, operation and affiliation follows.

Willard P. Johnson, M.D.,
Hospital Director.

January 14, 1971

GENERAL INFORMATION

The Seattle Public Health Service Hospital is a 262-bed general hospital. During the past fiscal year it had an average daily patient load (ADPL) of 180 with 112,000 visits to the Outpatient Clinic. The Hospital offers complete medical care to American Seamen, Coast Guard personnel and other legal beneficiaries. It offers training programs in medical, dental, pharmacy and related health services in affiliation with the University of Washington, Seattle University and the Community Colleges. Clinical and basic biomedical research is carried out by members of the hospital staff as well as by members of the University of Washington faculty who have established laboratories in the PHS Hospital.

The Hospital presently employs a total of 564 full-time staff as Commissioned Officers or Civil Service employees.

PATIENT CARE

PATIENTS—GROUPS SERVED (1969)

	Outpatients percent of visits	Inpatients admissions (percent)
Merchant seamen	28.1	33.1
Department of Labor, Employee Compensation	2.0	1.8
Coast Guard	8.8	8.3
Public Health Service commissioned officers	1.1	
Special study	1.9	3.3
Indians		6.5
DOD:		
Active duty and retired	11.6	11.8
Dependents active officers and retired	31.0	27.0
Dependents:		
Coast Guard	8.4	4.2
Public Health Service		
Other	7.1	4.0
Total	100.0	100.0

PATIENT CARE PROGRAMS

[A number of university teaching programs have a major dependence on the Public Health Service Hospital as is shown below]

	Average daily inpatient load (1969)	
	University Hospital	Public Health Service hospital
Gynecology	6.5	11
Medicine	43.8	59
Ophthalmology	1.8	3
Orthopedics	20.1	35
Otolaryngology	2.3	10
Surgery	29.0	45
Urology	7.1	29

INPATIENT SUMMARY STATISTICS (1969)

Service	Average daily patient load	
	PHS Hospital	University Hospital
Gynecology	11	6.5
Medicine	59	43.8
Neurological surgery	6	13.3
Ophthalmology	3	1.8
Orthopedics	35	20.1
Otolaryngology	10	2.3
Pediatrics	2	13.6
P.M. & R	12	26.0
Surgery	45	29.0
Urology	13	7.1
Dentistry	2	.4
Other		89.7
Total	198	253.6
Operating bed capacity	279	314
Occupancy (percent)	71	83.4
Average length of stay (days)	14.1	9.4
Admissions	5,125	8,200

OUTPATIENT STATISTICS (1969)

Service	Total visits	
	PHS hospital	University hospital
Cardiology	1,181	1,725
Dermatology	415	2,260
Endocrinology	1,538	1,048
G.I.	280	
General	29,973	
Gynecology	4,042	5,733
Obstetrics		10,229
Hematology	317	1,471
Medicine	1,080	9,148
Neurology and neurological surgery	717	3,915
Ophthalmology	8,134	4,534
Orthopedics	5,922	6,892
Otolaryngology	7,223	3,541
Pediatrics	8,015	5,867
Child health		8,679
P.M. & R.	1,364	10,846
Preventive medicine	10,051	
Psychiatry	646	12,669
Radiology		3,715
Surgery	3,891	7,758
Tumor	128	2,516
Urology	2,454	2,516
Total	103,128	102,546
Dentistry	17,263	4,797

Mr. ROGERS. Thank you very much, Dean. I think your testimony is most helpful in giving us an idea of the importance of the Public Health hospital there in your area.

You mentioned that you had had some discussions with the Department of Health Service and Mental Health Administration. About how long have they been going on, do you recall, Doctor?

Dr. VAN CITTERS. Yes. One week ago today.

Mr. ROGERS. A week ago?

Dr. VAN CITTERS. Yes.

Mr. ROGERS. Because I recall testimony from Dr. Wilson, that he had entered into no discussions on negotiations for the takeover of hospitals with anyone.

Dr. VAN CITTERS. It was my impression that Dr. Wilson was interested—Dr. Wilson was exploring the prospects of transferring responsibility for the patient and/or the hospital to a community corporate organization, or medical school.

Mr. ROGERS. Now, this contractual arrangement that you mentioned which would have to provide a long-term lump-sum contractual commitment, I presume that would have to take care of your secondary people as well as the primary, would it not? In other words, where will you take care of these people?

Dr. VAN CITTERS. The hospital population, as you are aware, averages about 200 inpatients, and about 120,000 outpatients. (Details are outlined in the paper.) But fundamentally, about 45 percent of those are primarily beneficiaries, and the remainder are secondary. We need that patient population for teaching purposes. It would be inappropriate to contract only for the primary beneficiaries. I do not know any legal means by which we can contract for the secondary beneficiaries. It is my understanding that they have what amounts to free choice.

Mr. ROGERS. Thank you.

Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

Doctor, have you stepped up the production of doctors and nurses in your school? Each session we put out a good deal of added money to the medical schools, and yet the percent of increase of doctors has not paralleled the dollars that we have appropriated. I wondered what your record of performance is there?

Dr. VAN CITTERS. We anticipated the need, the growing need for health manpower more than 5 years ago. Our school was operated at 75 students per class at that time. We began negotiations for an increase in our facilities. This is now under construction; and we are scheduled to go to 125 students in 1972, about a 50-percent increase.

But in advance of this, and at no expense to either the State or the Federal Government, and with no additional facilities, we increased our class this year to 102. That is about 25 percent. We are straining our facilities to the utmost, and we intend to continue to do so.

Mr. NELSEN. What do you find the attitude of young doctors to be? They tell me at the University of Minnesota that there is a greater interest in family practice than there ever has been before, which is something in which we are all interested.

Dr. VAN CITTERS. Well, our school has not previously had a department of family practice. We had not been oriented or geared in that direction. Here again we recognize the need and the shortage in our area. We have developed a new curriculum. We started a division of family practice, and the board of regents only last month approved the formation of a formal department of family medicine. In advance of this we had been training few people in family practice. We will graduate approximately 15 in family medicine or general practice this year, but our freshman class this year has declared itself on the specialities they intend to enter, and 52 members of our freshman classes opted for family practice.

Mr. NELSEN. I notice that in your hospital there is available bedspace of 279, and an occupancy of 180, or 65 percent of the hospital beds have been occupied by those that are designated in the act to be the recipients or the users of these beds. So the occupancy is quite low as far as the national average is concerned. But as I understand your testimony, the major contribution is the fact that the hospital has been used in the training of persons, nurses, doctors, and so forth. This is an extensive contribution to the cause of medicine, is that right?

Dr. VAN CITTERS. It is an added bonus at no extra cost.

Mr. NELSEN. Wouldn't it be a major one as far as this hospital is concerned?

Dr. VAN CITTERS. Yes; and I am not concerned terribly about a 70-percent occupancy rate. Hospitals do not operate at 100 percent, obviously.

Mr. NELSEN. No. I understand.

Dr. VAN CITTERS. And as a matter of fact, the census in the private hospitals in Seattle at this very moment is not substantially above 70 percent. They are not running 100 percent.

Mr. NELSEN. You are assuming that this hospital will be closed. I do not assume that. From the testimony of Dr. Egeberg, one of the objectives he seeks is to take a hospital and try to get greater occupancy by a greater community participation, and that reason is the

reason one of the major recommendations was made. So much of the testimony that we have been hearing assumes that the hospitals are going to be closed. And this is not true. I want to make that clear, that certainly no one could argue that a hospital should not be made into the most efficient hospital possible, and certainly its occupancy should be utilized by a community to the greatest degree. I am sure no one would quarrel about that.

Now, you mentioned something about——

Mr. ROGERS. I think he wanted to respond.

Mr. NELSEN. Yes. Go right ahead.

Dr. VAN CITTERS. None of Dr. Egeberg's assurances have come to me. And I have 400 medical students et cetera. You see, I have to train and find a place for them. And it is really no great comfort to me to read his statements in the press. I have to have something more substantial than that.

There is no likelihood that the community in Seattle can take over, or a community corporate structure can take on this hospital. We are currently operating a community hospital which the community is unable to support financially. I am sure you are aware that we are in more than a serious recession out there. We have a county hospital of about 300 beds which is affiliated with the university which is underfunded. And there is no likelihood, then, that the community can take over yet another hospital.

Mr. NELSEN. We sometimes investigate rumors. But my rumor is that there is no danger of Seattle being closed. Now, I have nothing firm about that. It's my feeling that the total performance of this hospital as tied in with the medical school makes a contribution that is quite extensive.

You mentioned that the hospital might be kept open for 4 or 5 years. Are you suggesting by that statement that you think maybe it should be closed in 4 or 5 years?

Dr. VAN CITTERS. I have already indicated that the hospital has not had major renovations or been brought up to code for some time. If the hospital is to remain open, let us say, a substantial period of time, someone has to make a substantial capital investment to bring it up, first of all, to fire safety codes. And second, the hospital was built 40 years ago, and it was built around 20-bed wards, et cetera. We think that in 5 years people will have free choice, that some form of comprehensive health care will have come about. And people are not by free choice going to go into 20-bed wards.

What I am saying is, then, is that the 5-year period has two implications. One is that by 5 years we will have had alternate solutions developed to take care of our training needs——

Mr. NELSEN. You are saying that you can see the need of a change in 5 years because of certain circumstances. I think maybe we are not too far apart. But there is a sort of general impression that everything is going to be closed. And there are only eight hospitals left. At one time we had many, but several of them have been closed. Certainly we want to see these hospitals doing the best possible job of providing service.

And I want to compliment you on your statement.

And I also wish to compliment you on your medical school and your expansion of trainees in all departments. Certainly I can understand

your concern. I would be likewise concerned, and I presume you are, about the SST program as it affects your city.

Don't answer the question.

Dr. VAN CITTERS. Of course we are.

Mr. NELSEN. I have no further questions.

Mr. ROGERS. As I understand it, what you are saying is, the hospital either must be modernized because nothing has been done, or some new building—it is not that you would have the facility done away with, or any of the services rendered there done away with, as I understand it, Doctor?

Dr. VAN CITTERS. The hospital can remain I hope, because as a Federal institution it can get along OK.

Mr. ROGERS. But the need exists to modernize it?

Dr. VAN CITTERS. The need exists, yes.

Mr. ROGERS. Is that what you are saying?

Dr. VAN CITTERS. Yes.

Mr. ROGERS. And it should be done within a 5-year period?

Dr. VAN CITTERS. It ought to be done right now.

Mr. ROGERS. Sure. But it will become very critical in 5 years?

Dr. VAN CITTERS. As a very practical matter—and we have faced this problem in other hospitals in the area—as a very practical matter it would be far better to start over new than to try to renovate that building.

Mr. ROGERS. I think this will be so in many of them, because they have not done any maintenance.

Mr. Preyer?

Mr. PREYER. Thank you.

Thank you, Dr. Van Citters, for your testimony. I would like to ask you if you can straighten up some questions on this bed occupancy rate. To the layman such as myself it is confusing. I understand you to say your bed occupancy rate is 70 percent, is that correct?

Dr. VAN CITTERS. At that hospital the statistics, yes, for 1969, about 70 percent.

Mr. PREYER. And I thought you said something also like, you are straining your facilities to the utmost at the present time?

Dr. VAN CITTERS. Referring to the teaching facilities at the university, right.

Mr. PREYER. To me that seems like a paradox, if you are 70 percent of capacity, and yet you are straining facilities to the utmost. We have heard some testimony that the reason some of these hospitals are operating at a, say, 70 percent of capacity is because they are only funded for staff services at 70 percent of occupancy. Is this a valid comment?

Dr. VAN CITTERS. The university affiliated hospitals consist of the university hospital, which runs most of the time over 90 percent, and the Harbor View Community Hospital, which last week was running 95 percent, and the Veterans' hospital, which seldom has empty or extra beds, and the USPH Hospital which has been running at about 70 percent. And the primary cause for this is the staffing problem that you have mentioned, the staffing and funding.

Mr. PREYER. If you had more staffing would your bed occupancy rate at the Public Health Hospital go up?

Dr. VAN CITTERS. We have had to close down services at that hospital for lack of funding. It is possible, for example, for secondary

beneficiaries to be referred to other hospitals. In particular the pediatric service at this hospital has been closed down, and eligible beneficiaries are referred to another hospital in town, the Children's Orthopedic Hospital at this time. But we have had to close down services for lack of staff, for lack of support.

In other words, I think what you are leading up to, then, is that the bed occupancy rate or census is not a true figure or not a true indication of need. And I will agree with you.

Mr. PREYER. In other words, are you saying that you are operating at a 70 percent bed occupancy rate because that is the level at which you are funded?

Dr. VAN CITTERS. That is correct.

Mr. PREYER. On your testimony I think you made two good points. One, you made a very strong case that the closing of this hospital would be a disaster to the supply of health manpower in the Pacific Northwest. And the second point, which I do not think any other witness has testified to, deals with transferring of these hospitals to community management. You apparently have had discussions of that subject and have dealt with the possibility. And it is your position, it is your conclusion that it is not advantageous in your situation at least?

Dr. VAN CITTERS. That is right. There is no way that we can operate that hospital as inexpensively as it is now being operated.

Mr. PREYER. Thank you, sir, for your consideration.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I certainly am quite interested in the presentation you have made. I think it is excellent.

I want to compliment you on your family practice program out there, and the fact that 52 percent of your freshmen students mean to pursue that, have expressed an intention to do that, I believe.

What is the size, if you do not mind, of your university hospital?

Dr. VAN CITTERS. It is 327 beds.

Mr. CARTER. 327 beds. With what other hospitals there in the area are you affiliated beside the Public Health Service Hospital?

Dr. VAN CITTERS. The university has students and trainees at 31 institutions, clinics, and institutions, ranging all the way from Anchorage, Wenatchee Valley Clinic, Yakima, et cetera.

Mr. CARTER. You mean medical students?

Dr. VAN CITTERS. Medical students, interns, and residents.

Mr. CARTER. Medical students is what I am referring to particularly.

Dr. VAN CITTERS. Medical students, are, offhand, at 25 of those.

Mr. CARTER. In 25 different hospitals?

Dr. VAN CITTERS. The great majority of them are very small, of course. But the major hospitals include the Harbor View Medical Center, 300 beds or so. The USPHI Hospital, a Veterans' hospital, and Children's Orthopedic.

Mr. CARTER. How large is the Veterans' hospital?

Dr. VAN CITTERS. It is about the same, approximately 300 beds.

Mr. CARTER. About 300 beds?

Dr. VAN CITTERS. The common tendency has been to build a thousand or fifteen hundred-bed university hospital on campus.

Mr. CARTER. What fraction of the total number of beds do the beds in the Seattle Public Health Service Hospital constitute?

Dr. VAN CITTERS. Probably 20 to 25 percent.

Mr. CARTER. Twenty to 25 percent?

Dr. VAN CITTERS. To enlarge, not all of the beds in all of the hospitals are of course available for teaching purposes.

Mr. CARTER. I was interested in your statement concerning the census of the hospital, that it would be up if the number of the employees were increased. That is a little bit contrary to the data which we have from the Public Health Service, which shows there has been a decrease from 1,800 daily census per day throughout the country in 1962 to a thousand per day as of this year, that is, there has been a great decrease in the number of patients which utilize these Public Health Service hospitals. And strangely enough, instead of a diminution of the staffing, we have had an increase in the staffing from 3,800 employees in 1963 to 4,441 employees in this year. So we see that actually the problem is incomplete utilization of so many of these facilities.

While the staff actually has been increased—and this is the problem that we are trying to solve—figures refute some of the statements which have been made here today—staffing has been increased, patient load has diminished over the years. So you see the need of this change, which was initiated, not this year, not last year, but about 1961 or 1962. We realize the value, of course, of this hospital to you. And it has been stated, I believe, that it will stay.

Dr. VAN CITTERS. I would just simply like to refer back to the staffing and census and cite again the example of the pediatrics care, the care of children at that hospital. We do not have a pediatrics staff, and therefore we cannot take care of the pediatrics patients.

Mr. CARTER. Were there ever or have there ever been any pediatric staffs in Public Health Service hospitals throughout the country, any of them?

Dr. VAN CITTERS. They are charged with the care of DOD dependents.

Mr. CARTER. That is not the primary thing, though, is it, Doctor?

Dr. VAN CITTERS. No; it is secondary.

Mr. CARTER. It is merchant seamen, and Public Health Service people, Coast Guard, and also oceanographic people. So we do not find many babies and young children going to sea.

Certainly we sympathize with you. We think you are utilizing this hospital well. However, we would like to see that census go up, if you continue to utilize it, from 64.5 percent to something like 88 percent. We feel like it would be of more service to our country if it were more completely utilized.

Thank you.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

Regarding utilization, Doctor, I was wondering what the implications were of your 20-bed wards. Would they give way in time to more private arrangements? Wouldn't this lead to fewer beds per hospital unless extensions were made?

Dr. VAN CITTERS. Well, there is simply no way that you deliver medical care in this era in 20-bed wards. That is gone, those days are gone forever. As I have indicated, if you look ahead, there will be such a thing, I am certain, as some form of university health coverage. People will have free choice, and they are simply not going to go back

into that system. No one is building hospitals today with 20-bed wards. It is in fact unusual to find new hospital construction involving two-bed wards—it is almost all private beds. There is no reason that these dependents, or welfare patients, should be put into 20-bed wards. Human dignity is the same as in a private ward.

Mr. SYMINGTON. Is this happening now in your hospital?

Dr. VAN CITTERS. We have a hospital under construction, and there are no 20-bed wards in it, I assure you.

Mr. SYMINGTON. When you talk with people from Washington about your problems, why don't they see the problem as you do? What do they fail to note?

Dr. VAN CITTERS. I am not certain I can answer that. It is my understanding that the closure was threatened on an economic basis, that these hospitals would not be funded. And I cannot go into the background for this.

Mr. SYMINGTON. But is there a steady exchange of communication between you and these authorities concerning the value to your community that your work provides? Do you feel that they have taken that into full consideration?

Dr. VAN CITTERS. No, we have not been consulted on this decision. As a matter of fact, our first awareness that there might have been a problem came from the press, where actually we were approached by reporters and were asked, what are we going to do now. It was only then that we developed the background and learned of the possibility. As a matter of fact, we have not been consulted in very much of this at all.

Mr. SYMINGTON. Would you think that such consultation would make for sounder decisions?

Dr. VAN CITTERS. We would welcome it, of course. It would seem like the way to do it.

Mr. SYMINGTON. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy?

Mr. ROY. Thank you.

I want to thank Dean Van Citters for coming here and being with us this morning.

And I would like to congratulate you, Dean, and your medical school on the MEDEX program and the increase in the number of students in the medical school which you have achieved so far.

I have heard about the university of Washington for a number of years. To be honest with you I am a little biased about the University of Washington, because I can remember about 20 years ago when I was leaving Northwestern a number of other people were leaving to go to the University of Washington and establishing that medical school.

I have one question. If we are able to restore the funds necessary to operate your hospital, has any irreparable damage been done so far with respect to your staffing or your plans for enlarging your classes?

Dr. VAN CITTERS. At this point, no, we have lost no staff. And we are continuing to accept students on the basis that that hospital will be there.

Mr. ROY. Do you feel that there is a definite time limit with respect to when you must know?

Dr. VAN CITTERS. We learned through the press that closure might have been anticipated as early as the first of July. And this would, of course, be unthinkable.

I should point out to the committee that we do hold a contract with the USPH Hospital, which is a 2-year contract which has 16 months to go. Now, I suppose that if in fact the hospital is not funded, then our recourse is to sue the Government, which I gather is not terribly successful. It would not do much for our training programs.

We also have contracts with the 50 young men, the interns and residents who will start there on the first of July. We usually sign them up well in advance, of course. And I have not heard of any alternate course that is planned for either these young men or any others.

Mr. ROY. Does it appear from your vantage point that a budget decision was made, and after that there was some investigation into better use of the hospital?

Dr. VAN CITTERS. It occurs that a budget decision was made while there was a lot of scrambling going on.

Mr. ROY. Thank you.

Mr. ROGERS. Thank you very much, Dean. It has been most helpful.

I am hopeful this committee can get some very positive action very soon to correct the situation. And I think the Congress will do it, if it is not forthcoming from the administration.

Also this committee will be working on health and manpower legislation. And undoubtedly we would like to call on your talents there too. And we would be in touch with you, because it is very impressive to have a 50 percent increase in the production of your medical students.

Dr. VAN CITTERS. Thank you very much.

Mr. ROGERS. It is most impressive. And we are grateful to you for being here.

Dr. VAN CITTERS. We welcome the opportunity.

Mr. NELSEN. Mr. Chairman, I would like to pursue one point.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. Regarding your 5-year suggestion, I assume that it is your judgment as an expert, that this hospital in 4 or 5 years will be in such a state of repair, or the age will be such that you would not continue to pour money into this facility but would move toward a new structure. Is that true, or is it not true? Is my impression correct.

Dr. VAN CITTERS. We would have to move to a new structure. And the alternate or extra reason is the reason I gave Dr. Roy, that you simply will not be able to put patients into a facility like that.

Mr. NELSEN. There is really nothing that you could do with a hospital of that kind. This structure is many years old. Under present standards of design the building could not be assumed to be practical?

Dr. VAN CITTERS. Let's face it, this system has been starved for many years, and has not had the funds or resources to keep up with the times.

Mr. NELSEN. Had it not been starved, had it been restructured inside, could it still have been a usable building?

Dr. VAN CITTERS. Surely. We are in fact in the process of renovating the Harbor View Medical Center, which was built within a year or two of this one. And we are converting those 20-bed wards into private and double rooms.

Mr. NELSEN. The point I want to make is that you indicate that if you were in charge you would move to a new building, and you would not expect to continue this old facility forever, this is, I believe, the way the Public Health Service people feel, that finally you are going to need to move to another building.

Dr. VAN CITTERS. Were I in charge we would move to a new building which we would build adjacent to the university hospital.

Mr. NELSEN. That is great. I would be all for that.

Dr. VAN CITTERS. We are too.

Mr. NELSEN. Thank you very much.

Mr. ROGERS. Thank you very much, Dean. We appreciate your appearance.

Our next witness is Mr. O. William Moody, who is the administrator of the AFL–CIO Maritime Trades Department. I believe he is also appearing for the Seafarers International Union of North America.

STATEMENT OF O. WILLIAM MOODY, ADMINISTRATOR, AFL–CIO, MARITIME TRADES DEPARTMENT, AND ALSO ON BEHALF OF SEAFARERS INTERNATIONAL UNION OF NORTH AMERICA; ACCOMPANIED BY BERTRAM GOTTLIEB, DIRECTOR OF RESEARCH, TRANSPORTATION INSTITUTE

Mr. MOODY. That is correct, Mr. Chairman.

And I have with me, if I am permitted to do so, Mr. Bertram Gottlieb, who is the director of research for the Transportation Institute, a management oriented nonprofit organization dealing with the problems of principally maritime transportation.

Mr. ROGERS. Mr. Gottlieb, the committee welcomes you too, sir.

Mr. GOTTLIEB. Thank you, sir.

Mr. ROGERS. Thank you. And we would be glad to receive your presentation.

Mr. MOODY. Mr. Chairman, and members of the committee. My name is O. William Moody, and I am the administrator of the AFL–CIO Maritime Trades Department. This department is a constitutional arm of the AFL–CIO, created by the national trade union center to represent organized labor's interests in maritime and related fields. There are 42 national and international unions which are affiliated with the Maritime Trades Department. Together, these unions have a membership of more than 7.5 million American workers. These unions are affiliated with the department because they represent workers in all phases of the maritime industry—seagoing and shoreside; shipping, shipbuilding, cargo handling and supporting trades and services.

In addition to appearing here today as the spokesman for the Maritime Trades Department, Mr. Chairman, I am also appearing on behalf of my own union—the Seafarers International Union of North America—which represents men who man our merchant ships sailing from the Atlantic, gulf and Pacific coasts, and from the Great Lakes, which now constitute this Nation's "fourth seacoast."

On behalf of these merchant seamen in particular, as well as of their union organizations, I am grateful for the opportunity to appear before you today.

We are very much in debt to the committee for its interest in this problem and for its work over the years in the struggle that has been going on to rebuild the American merchant marine. In recent months you have of course increased our obligation to this subcommittee, because of the attention you have given the issue before you, the proposal to liquidate the Public Health Service hospitals. In particular you, Mr. Chairman, have been among the first to raise your voice against this proposal, and to assert that the services of these hospitals should be expanded rather than eliminated. And we deeply appreciate that, sir.

This, of course, reflects our own view. American merchant seamen look upon these hospitals as an integral part of their lives—and indeed, some of them owe their lives to the care they have received in them. The seamen rightly believe that these hospitals not only provide top-level medical care, but are uniquely oriented to the special needs of merchant mariners.

Apart from all other considerations, Mr. Chairman, this orientation makes the Public Health Service hospitals indispensable, for it cannot be duplicated in any of the alternative institutions suggested by the Department of Health, Education, and Welfare.

The American seaman has always had unique health problems. He is at sea for long periods of time, during which—with few exceptions—the only medical care available for him is first aid. Comprehensive treatment of illnesses and injuries must often be deferred until the return to home port when the ill or injured seaman needs the prompt medical care which only a Public Health Service hospital can provide.

This care must be immediately available, even for ailments which for the rest of the population are less demanding. To avoid loss of employment—and income—a seaman needs to get into the hospital promptly so he can be out in time for the earliest possible sailing. The time pressure increases as U.S. merchant vessels reduce the time they spend in port.

Now, in these hearings we have heard a great deal about the possibility of transferring these hospitals to some kind of community control. We believe in the maintenance of the U.S. Public Health Service hospitals under the direction and control of the Public Health Service. We favor broadening and extending Public Health Service hospitals to provide greater service for the total community, and to provide leadership in the development of superior, more economical methods of delivery of medical services to the population at large.

But we submit that in the case of these primary beneficiaries, seamen and coastguardsmen and tugboat men and fishermen, that their priority needs are such that if they are subjected to community control, as would be the case in a community hospital, that they would not get the kind of priority care that is demanded of them in the industry in which they work.

The availability of top-quality medical care on a priority basis in Public Health Service hospitals has made the American merchant sailor the healthiest and most productive in the world—qualities whose preservation is vital to the success of the Nation's expanding maritime program.

By adopting the Merchant Marine Act of 1970, Congress committed the country to maritime expansion. Many new vessels will be built—

ultimately, as many as 30 a year, and we believe that additional numbers will be built through private capital. But the success of this program depends upon the ability of American flagships to compete for cargoes. Every unnecessary cost makes this indispensable goal harder to reach.

On this basis alone, it seems to us, the Public Health Service hospitals are as essential today as they were when the first one was set up in 1798—an era when Government services for citizens were not as commonplace as they are today.

Let me remind the committee that there has been a drastic shrinkage in the Public Health Service hospital system over the last 25 years. It has paralleled the shrinkage in American flag shipping. In 1946 there were Public Health Service hospitals in virtually every principal port city in the United States. In 1946 there were 29 hospitals. Today there are only eight hospitals and 26 outpatient clinics. Four hospitals have been closed in the last 5 years alone.

It appears self-evident to us that the new growth of the American merchant fleet should logically be accompanied by growth—not shrinkage—in Public Health Service facilities for seamen. We hope that the inquiry contemplated by the concurrent resolution will reach the same conclusion.

In that connection, Mr. Chairman, we urge that Congress not only express its views with respect to these hospitals, but take steps to see that its views are given proper weight. For example, Congress has consistently appropriated funds for the upkeep and modernization of the Public Health Service hospitals, surely indicating that Congress wanted them maintained. But much of this money was never spent. This is, at the very least, deplorable.

The danger, as we see it, is that an apparent victory in the present, highly publicized contest may be subverted in the semisecrecy of bureaucratic maneuver. Although the Comptroller General's latest opinion on Secretary Richardson's plan would seem to preclude HEW from closing all the hospitals simultaneously, the Secretary—or some successor—could still pick them off one at a time—just as has been done in the last 5 years. We hope the concurrent resolution will not only be enacted but implemented; and that Congress will join us in maintaining constant vigilance against the possibility of piecemeal attacks.

Up to this point, I have discussed the hospital issue only in terms of the merchant seamen, but as the committee knows, the role of these institutions is far broader. The definition of "seamen" in itself encompasses fishermen and tugboatmen, as well as those who sail the oceans, the Great Lakes and the inland waterways. In addition, coastguardsmen, who are among the primary beneficiaries, injured Government workers and a variety of other groups use their facilities. And because of their unsurpassed professional excellence, the hospitals have served as teachers, exemplars and training grounds for others.

The most illuminating evidence of this was provided by hearings in the various hospital communities conducted by "factfinding commissions" dispatched by the Department of Health, Education, and Welfare. I might add, after the hue and cry arose over the prospect of the closing of the hospitals. The purpose of these commissions was to gage public reaction to the hospital closings. If, as might be pre-

sumed, HEW hoped to find widespread indifference, the results must have come as a shock.

Members of port councils of the Maritime Trades Department attended all these hearings and gave us first-hand accounts. They were remarkably alike in substance.

Most of the hearings drew overflow audiences of two or three hundred; often it was necessary for some to leave so others could be heard. In attendance were academicians, hospital administrators, surgeons, community leaders, school teachers, servicemen's wives, retirees—a full cross-section of the residents. All testified that the Public Health Service hospital in their community provided the best possible care, with facilities and personnel of the top rank. They explained why the hospital was irreplaceable, and expressed the deepest dismay at the prospective closing.

Most of these groups foresaw a difficult future without the Public Health hospitals, for numerous medical and health programs are built around them. This fact was brought out in the Webster report on the Public Health Service hospitals, the only authoritative study ever done on them. This study stated that 85 percent of the PHS budget is spent for training programs. Thus, while these institutions were established primarily to provide health care to seamen who still comprise 52 percent of their patients they have acquired a public function on a much broader scale.

They are more than a group of hospitals; they have developed into a vital national health resource.

It is almost incredible to us, Mr. Chairman, that in a period when the deficiencies of health care in America are under searching examination, and when all sides, regardless of their other differences, agree that more and better facilities are desperately needed—that in such circumstances there should be a serious move to close down eight of the best-run hospitals in the Nation.

We are confident that the committee shares our view. And to conclude on a note of optimism, I hope that the public outcry precipitated by the attack on these hospitals will have a "frontlash" that will lead to an expansion of the Public Health Service program, and will contribute to the development of an effective national health service for the American people as a whole.

Thank you, sir.

Mr. ROGERS. Thank you very much, Mr. Moody, for your statement.

Certainly the concerns that you have expressed, I think, are shared by a great number of Members of Congress. And we hope to do something about it.

Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

Mr. Moody, I want to thank you for your testimony. You represent your people very well.

I did notice that you suggested these hospitals be oriented to take care of the total problem, not only the seamen, but also to provide and expand their available resources to a community. I want to compliment you on that observation. Really we are searching for some way to do this very thing. And I believe this is what the administration wants to do.

Now, you made the statement that the Public Health Service would close down the eight hospitals. I can assure you that there is no such intention.

How long have you been in your position?

Mr. MOODY. I have been a representative of the Seafarers Union for almost 23 years.

Mr. NELSEN. Have you ever appeared before a committee before in protest to the closing of these various hospitals in the past?

Mr. MOODY. Yes, Congressman Nelsen. I appeared before the Senate Subcommittee on Health in 1969 to protest the threatened closure of the hospitals in Detroit and Savannah. I am sorry to say without any degree of success. Those hospitals are now closed.

Mr. NELSEN. I see. So you come here with a good history of having observed this problem. I compliment you on that.

I can understand your concern that by a transfer of the hospitals the seamen might find themselves in a less priority position. Because of the type of work they are in, when they need it, they need immediate attention, so your concern is that we should not in any way contract for hospital operations in a manner that might diminish from the attention of the people that you represent. I take that to be the burden of your testimony in that respect, is that right?

Mr. MOODY. That is correct.

Mr. NELSEN. I compliment you on that. I think this is the intent of the act in the first place.

I also want to emphasize that in my judgment there is no possibility that eight hospitals will be closed. Maybe none should be closed. But I think the major objective is to make the hospital available to a greater involvement. There is also an economic problem involved of utilizing the space, the personnel, and looking ahead. I think that this committee will search carefully to protect what you are trying to protect. because I think it has merit.

No further questions, Mr. Chairman.

Mr. MOODY. Mr. Chairman, could I respond briefly to Congressman Nelsen's comments?

Mr. ROGERS. Certainly.

Mr. MOODY. I want to make it perfectly clear that in the maintenance of this system we think it is necessary that we maintain priority treatment for these primary beneficiaries.

Second, in listening to the hearings here yesterday and the hearings before the Senate subcommittee earlier this week, I gather that there is a feeling on the part of some people that there might be some political partisanship involved in this issue. We want to make it perfectly clear that we do not think this is part of the problem. We have lived with this problem through administrations elected by both political parties. These hospital closures started in 1946. We are convinced that this question—the heart of this issue goes to a hostile bureaucracy within HEW to the system, not just the hospitals or individual hospitals, but to the system itself.

I wish we could share the confidence you have, Congressman Nelsen, that these hospitals, or none of these hospitals of the remaining eight would be closed, or that a substantial number of them would be retained, or that they will not be knocked off one by one by the process of attrition. But in listening to HEW witnesses on the Senate side

the other morning I did not hear one single unqualified assurance to that committee on that point. And in the absence of any unqualified assurances, naturally we feel great concern over this matter.

Mr. NELSEN. I think you are to be complimented for your concern and your representation of the people that you represent. And I want to again say thank you to you.

Mr. MOODY. Thank you, sir.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Moody.

Most of our witnesses have testified out of a sense of urgency, because they are told the hospitals in their district are being threatened with closure. But you are testifying, I gather, for all eight hospitals. And what you fear is that a witness like Dr. Van Citters, who was just here, and who is doing such a great job, will still have his hospital closed on an individual basis. What you are saying is, we also need to fear the pick-them-off-one-at-a-time approach?

Mr. MOODY. Yes, sir. We think the track record demonstrates that this is what will happen.

Mr. PREYER. Thank you, Mr. Moody.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Certainly I am in sympathy with the American seamen. And I want to see that they get primary care in the future as they have received in the past.

However, there are some facts that we must realize. And that is that there has been a shrinkage of the merchant fleet in our country over the years, has there not?

Mr. MOODY. That is correct.

Mr. CARTER. And as a result, there has been a shrinkage in the number of merchant seaman. And actually there has been a decline in the number of admissions of American seaman into the hospitals there—for instance, in 1962 the daily admissions were 1,608 and in 1971, 1,010.

With this diminution of the demand for hospitalization, of course it is economic to reduce the number of beds in the hospital. It is a matter of economics.

Of course, when the Merchant Marine Act of 1970 goes into effect, certainly provisions will be made for that. But how many merchant seaman do you think will be on each one of those ships? Will we produce 30 percent? What would the estimate be?

Mr. MOODY. I could not answer that question, Congressman Carter. It would be an average for most of them of 30 to 35, something like that, based on today's number. But this is a matter of manning scales that has to be worked out.

Mr. CARTER. Suppose we had an increase of 900 per year. Then only a small percent of those would need hospitalization, wouldn't they? Would that within itself justify an increase in construction and maintenance of this super number of beds which are not used amounting to—well, from 150 to even 200 beds in some of these hospitals that lie vacant and are not utilized in our country? We want to provide the service for you, and we are going to. But it seems to me that we must, as you have said—as you pointed out in your statement, we have got to allocate beds according to the need. And we mean to do that, I want to assure you of that very fact.

Mr. MOODY. I would like to point out that I do not think—of course I am handicapped somewhat because you have the census figures—but I am not at all certain that the decline in the caseload, the merchant seamen's caseload, is altogether the result of the declining number of merchant seaman in the period that you refer to, because over the last 5 or 6 years we have had great demand on our American merchant marine, the demand, for instance, of the sealift to Vietnam. I think that this decline is due in considerable measure to hospital closures themselves. Because in many instances patients who would have gone to these Public Health Service hospitals have either just not gone there, or they have just disappeared somewhere. We just do not know what has happened to them. We do not think an adequate study has been made of this situation.

Mr. CARTER. That may be so. But we still would have had eight hospitals and 33 clinics. And of course they have connections with these clinics, and they transfer them in case they need hospitalization to the hospital. So it is obvious to me that the smaller utilization of the hospital, the shrinkage and the utilization of the beds in the hospital, parallels the shrinkage of your fleet, as you state, and as we think, this is just one of the economic facts of life. But for my part, I want to assure you that I want a strong merchant marine, and one that can sustain itself if possible. And I will support measures to see that they have proper medical attention. But this is a time in which unnecessary beds are just an experience.

Mr. MOODY. We do not, of course, agree, Congressman Carter, that we have any unnecessary beds. Being an old country boy, referring to these bed statistics of HEW, the Public Health Service, if you are milking the cow you can pretty well control the production. And we are impressed somewhat by the relationship of insufficient staff to bed occupancy. We think that there is some validity to what has been said by numerous witnesses on this point.

Mr. CARTER. As another old country boy, Mr. Moody, did you ever actually milk a cow?

Mr. MOODY. Yes, sir.

Mr. CARTER. Where?

Mr. MOODY. Would you believe a place called Riverview, Fla.

Mr. CARTER. I have done much of it, I grew up on a small farm myself.

Mr. NELSEN. Off the record.

(Discussion off the record.)

Mr. ROGERS. I think it might be well too for the committee to know, and we will ask HEW to let us know if these figures that they give us also include the contract services where they have closed hospitals. For instance, in Chicago they closed a hospital. Now, merchant seamen may be coming in there. And if they have an emergency they have to go into a hospital there. They do not count them in these figures because they are not going to a Public Health hospital. They have to pay for them, and probably pay more than they would if they went to the Public Health hospital. And we will try to get some of those figures that might give a more thorough picture.

Mr. Preyer?

Mr. PREYER. I have no questions, thank you.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. Moody, I was interested in your statement, page 3, "Every unnecessary cost makes this indispensable goal harder to reach," the goal being the ability of the merchant flagships to compete for cargoes. I think that many of us have been quite unfamiliar as the years have gone by with the problems of the merchant marine are beginning to wake up to the fact that we have lost the business, really, to countries some of which we whipped in war and others that we helped. Do the seamen of the other countries enjoy these hospitalization benefits back home to a greater degree or to a similar degree to ours? Is this a major factor?

Mr. MOODY. All maritime nations—I am speaking of the Scandinavians and the Japanese, et cetera—take care of their own very well, and I would think to a better degree than we do. And in the whole area of their maritime operation they take care of the business side as well as the humane side, I think, better than we do here.

Mr. CARTER. Mr. Chairman, will the distinguished gentleman yield?

Mr. SYMINGTON. Yes, indeed.

Mr. CARTER. What is the comparative scale of the American merchant seamen and the Japanese or the Norwegians?

Mr. MOODY. Of course the wage scale of the American seaman is higher.

Mr. CARTER. Yes, sir.

Mr. MOODY. But the wage scale of the American seamen is comparable to the living standards of the American citizen. The wage standards of the Japanese seamen and the Scandinavian seamen, and the British seamen, who also have strong unions, are comparable to the living standards of the nations that they are employed by.

Mr. CARTER. But ours is much higher?

Mr. MOODY. That is correct.

Mr. CARTER. And in fact, many people say that that is the reason—we just might as well be frank about it—why we have gone down in our maritime trade, because we have priced ourselves out of the world market. But this is a side issue, and I hate to bring it in.

Mr. MOODY. We insist, both management and labor, in the American maritime industry, that this is really a myth that ought to be laid to rest. The American merchant seaman has the highest productivity of any of his counterparts anywhere in the world. It has risen 400 percent since World War II. We think that a large part of our maritime problems have resulted from misguided Government policy. We are extremely grateful to your side of the aisle in that President Nixon has displayed more leadership in trying to turn this thing around than any President since Franklin D. Roosevelt. The Merchant Marine Act of 1970, which was given so much impetus by this committee, the full committee, is the first major maritime legislation and the first overhaul of maritime policy in this country since 1936. And we think we have got a better day coming.

Mr. CARTER. I certainly hope that we have.

Mr. MOODY. Thank you, sir.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you.

I certainly hope that we have the healthiest seamen, just as I would wish to have the healthiest citizens of all descriptions in the world.

But I think that we could well have the healthiest seamen and still be losing the business. And undoubtedly you have pointed out an unnecessary cost. But since you do so, I hope that we can rationalize all the other necessary costs to the point where we can be competitive, because we certainly do not want to build 30 ships a year and be unable to find a use for them.

Thank you.

Mr. ROGERS. Dr. Roy?

Mr. ROY. Mr. Moody, could you foresee the time that American seamen had greater income than other seamen, but lesser health care?

Mr. MOODY. If this present trend continues I would certainly agree that we can foresee that time. If we discontinue this hospital system that Congress in its wisdom foresaw the need for in 1798, I think it certainly will result in a decline in health service to seamen.

If I may, doctor, I would like to point out one thing. And it goes to this whole question of contract services. I can recall the time when there was a form of, you might call it a type of contract medicine, that was practiced in the American maritime industry, whereby the companies, the steamship companies had under contract doctors who went aboard ships when the crew was signed on to conduct physical examinations of the members of the crew. Now, obviously a small room in the officers' quarters behind the bridge, with a line of men, 35 or 40 men lined up outside, is not the ideal place for a thorough physical examination. And I am not being critical of the doctors in this regard, because they were obviously working under a handicap. And so really the examination consisted of cough and pass on. And incidentally, a good many hernias were missed this way too.

In recent years the steamship management—and we think that we played some part in this, because we felt it was necessary for the protection of our people, and really negotiated it with them—we have gone into a joint program of preventive medicine. And many of these same contract doctors that I spoke of, some of them are now heading up our preventive medicine program, which consists of annual, and oftener where indicated, thorough physical examinations, which have resulted in a better standard of health for seamen generally, and also may be reflected somewhat in the declining caseload that Dr. Carter mentioned. We are quite proud of that program. But we also think that this in itself sort of points to the weakness also in contract medical services for seamen.

Mr. ROY. I want to thank you for pointing out one thing which had not occurred to me and which I think perhaps deserves emphasis. That is the fact that if these hospitals were running at 90-percent-plus occupancy, that it would result in elective surgery being sort of on call. And we cannot say that a seaman will be available for call 2 to 4 weeks from now, because he might well be halfway between Seattle and Hong Kong. So I can see some advantage in not having the high occupancy rate we have in some other hospitals.

Thank you.

Mr. MOODY. Thank you.

Mr. ROGERS. Thank you, Mr. Moody and Mr. Gottlieb. We appreciate your help.

Our next witness is Dr. John J. Walsh, vice president for health affairs of the Tulane Medical Center, New Orleans, La.

Dr. Walsh, we are delighted to welcome you here. We do appreciate your coming to give us testimony that would be, I am sure, helpful in this whole matter.

STATEMENT OF DR. JOHN J. WALSH IN BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. WALSH. Thank you, Mr. Chairman.

I am here representing the Association of American Medical Colleges, to present our reasons why we oppose the closure of the Public Health Service hospital system, and why we oppose its transfer to non-Federal auspices.

Basically one could summarize our position by saying that we look upon the Public Health Service hospital and clinic system as a great national resource, a resource which, if handled in the manner that is proposed, namely, transferral to community institutions and nonprofit organizations, would not only cost the taxpayers a great deal more of money, but would lose forever the unusual potential that these hospitals offer.

The first reason relates to the area of health services research and development. Now, please do not misunderstand me. I mean very definitely that these hospitals would be concerned with treating patients, providing quality care. But as this committee is well aware, there is probably no problem other than the welfare issue facing public administrators on the domestic scene which is more pressing, more divisive, and more emotional than the health care problem.

There are many reasons for this—the growth in population, the rapid escalation of cost. I think the general philosophy among the citizenry now is, rather than health care being a privilege, it is a basic right. And regardless of one's position on this, this is the consensus.

Basically, then, we have to—and when I say "we," this obviously has to be led by the Federal Government—have to place great emphasis on study, demonstration, and experimentation which will render health care more efficient, more effective, and more economical.

In essence this relative handful of hospitals presents an unusual opportunity. They are completely controllable environments. Those of you who have been either patients, on hospital boards or hospital staffs, realize that most hospitals are not completely controllable environments. But these are completely controllable environments in which can be performed very sophisticated continuing study on all aspects of health care.

For example, the very basic problem of health care facility construction. I would recommend that these hospitals not only be continued, but modernized and, in several instances, replaced. From the very beginning of their design they would be oriented toward a scientific approach, toward attempting to solve some of the major problems in the health care field today.

What are some of these?

Well, for example, in the area of equipment. Currently I do not know how many dozen input and output devices there are which function as terminals in computerization programs. We all recognize the desirability of the maximum application of computerization in hospital operation and in health care operations generally. Now,

there is no way to determine performance standards for these things. If these are going to be used they are going to have to be distributed throughout the hospital. Somebody is going to have to compare these in terms of durability, in terms of acceptability by the professional staff, in terms of degree of maintenance needs, and in terms of cost effectiveness. With respect to the health care facilities, how should they be designed, what maintenance programs can be determined to be cheaper, and better? What type of construction materials are needed? The problems of environmental control, zoning of the services within the hospital, spatial relationships within the hospital? These hospitals can be used in a way as underwriter laboratories to develop performance standards for health care equipment, and construction—something we do not have today.

Certainly the same application can be made in terms of supplies. What disposables are safe, how can they be used most effectively, where isn't it effectively economical or desirable to use disposables? The most important contribution can be in the area of health manpower. And as you know, from 60 to 70 percent of a hospital budget goes into its personnel. The real savings that can be made in terms of delivering health care will be in the area of health manpower. These PHS hospitals can be and are particularly suited to evaluating ongoing types of professionals and subprofessionals, such things as task analyses, developing task requirements for hospital departments, service needs of different types of patients. The hospitals are particularly adapted for the development of new types of personnel.

This is one example of why we feel these hospitals are invaluable resources. I think that the greatest contribution we can make today is in terms of research in the organization, delivery, financing, and composition of health care.

Now, there is another reason why we oppose the transfer of these institutions to community operation, or their closure. And that relates to the Emergency Health Personnel Act. There are, I believe, eight hospitals and 30 clinics, each of which could act as a base tomorrow for launching the implementation of the Emergency Health Personnel Act. Very importantly, from the Government and the taxpayer's viewpoint, this could be done with a tremendous multiplication effect in terms of the dollars involved, because in each of these hospitals the people are on duty 24 hours a day, the cost is built-in, and they would provide a professional team to support the EHP effort. In none of the cities in which there are PHS hospitals or clinics is there such a high distribution of health care that there are not people who are medically indigent and who do not need health care. That is true in New Orleans. I have been told that in Baltimore there are approximately 174,000 people in the inner city, who are indigent and are not receiving health care.

Thus we could implement the Emergency Health Personnel Act, multiply its effects many times while using the same amount of dollars, and do it tomorrow and start delivering the health care that we keep promising people that we are going to deliver but we do not deliver.

Now, there is another factor relating to the Emergency Health Personnel Act that should be mentioned. We talk somewhat glibly of providing health care to the medically indigent in the ghettos and the

urban areas, the rural poor areas, and areas in the country with insufficient physicians where the medical society would like some Public Health Service people assigned to help them. But we really don't know the best way to do this. How, for example, do we engender in these people a sense of responsibility in terms of seeking health care? Very importantly, one of the current buzz words, as you know from your numerous witnesses, is preventive care. Certainly we all subscribe to preventive care. But in all honesty, what preventive measures are worth the investment? What preventive measures pay off? How would we compare one preventive measure against another, assuming a constraint in dollars? And again, the utilization of the PHS hospitals would provide a unique opportunity to study how we can better provide this care, how we can provide more care, more efficiently and at least cost.

There is another area of concern arising from the transfer of the PHS hospitals to non-Federal auspices, and that is cost. Currently the per diem cost in private institutions in all of the cities in which these hospitals are located, approximates twice the cost in the Public Health Service institutions. More importantly, that per diem cost in Public Health institutions includes complete professional services, whereas in the private institutions it does not.

There is another major cost problem if these hospitals would be transferred or contracted over to nonprofit institutions or agencies. And that is composed of many hidden costs that these agencies could not absorb and could only pass back onto the Government. You can start out with small items as insurance. The Federal Government does not insure its installations. In the case of the New Orleans hospital, that would probably cost about $150,000 a year. Moreover the PHS hospitals generally have a staffing ratio, that is, the ratio of full-time employees to inpatients, of about, I believe, 1.6 or 1.7. The national average is approaching 3.

Mr. ROGERS. I think that is a very important point. Could you repeat that?

Dr. WALSH. The staffing ratio which represents the number of full-time employees to the daily census, in the Public Health Service hospitals I believe approaches 1.7 or thereabouts. In civilian hospitals it is somewhere in the range of 2.5 to 3. Neither LSU nor Tulane could operate the institution with that staffing ratio. This low ratio is a manifestation of the slow starvation of the PHS hospital system that was mentioned by previous witnesses.

I think everyone is aware that the facilities are old. They would have to be extensively refurbished or replaced, but the cost of modernization of hospitals of that nature runs 90 to 110 percent of the cost of replacement. There is no question that these hospitals should be continued, but modernized or replaced when necessary.

The last item that the contracting private institution would have to provide and in turn pass the cost on to the Government is the extensive backup of Federal services—for example, the differential in purchasing costs between the Federal Government and the private institution or nonprofit institution—the tremendous backup services that these hospitals are provided through, for example, the General Accounting Office, and through the consultative services with and without the Government.

In my estimation these hospitals on transfer would cost approximately twice as much as they are costing now, and the Government would give up this tremendous opportunity to develop four or five hospitals that are truly devoted to health services research and development, for which there is, as far as I know, no institution in this country that is really totally oriented and operated. It would mean the use of new people, systems engineers and industrial engineers, people who analyze, jobs, economists, et cetera.

But this is where we can take a solid and significant step in terms of rendering our health care even better, and at a lower unit cost.

There is a fourth reason why we oppose the closure or transfer of these hospitals. The hospitals traditionally have represented an important entry point for career personnel in the Public Health Service. The Government now has direct or indirect responsibility for the medical care of, I guess, 60 or 70 million people. There is no question that the Government is getting deeper and deeper into the health care business. It is assuming the greater and greater responsibility for more and more people, more and more professionals, and more and more services, directly or indirectly. And it seems to me now, more than ever, we need an extremely competent, objective, trained, and experienced career group who are going to represent the Government and the citizens' best interests in helping to manage this national health care program, under whatever auspices it is directed.

Dr. Van Citters discussed at length the importance of PHS hospitals in training. And it is equally important in New Orleans and in the other cities. Among other things, there is no guarantee that with these institutions being transferred to other auspices that the training program will be continued.

Second, there is a very real need for the beds and the patients who are in these beds for teaching purposes. Both LSU and Tulane are planning expansion, Tulane a 30-percent increase, and LSU a 30-percent increase in medical student body. We both have been counting on future Public Health Service beds in New Orleans, although we are of a mind that we each need from 300 to 400 private beds to strengthen our teaching programs.

Now, the fifth area that warrants consideration when the future of these hospitals is considered and debated is the area of community services. PHS hospital community services are very varied, but they are invaluable. For example, invariably they present the prime local disaster resource. And this was particularly demonstrated in New Orleans during Hurricanes Betsy and Camille, and in Seattle during the Alaskan episodes.

But in addition to that function they have very varied programs. For example, in New Orleans they happen to also house, and in effect by virtue of it not costing any more, provide the manpower for the State poison control center, which is the backup unit to the national poison control center, to which it is connected by a computer.

The hospital has provided in the case of New Orleans a place where the Headstart examinations could be done, because there was no other suitable place. The hospital was used at nights and on weekends, with volunteers from the staff and the community and hired people conducting these examinations. The PHS hospitals represent unusual opportunities in terms of training programs. The New Orleans hospital

over the last few years has trained 1,500 people from the community, people who were basically welfare clients, who were trained in various aspects of the health care system, such as animal house attendants, orderlies, or telephone operators. They probably made it possible for 100 to 200 of these people to obtain permanent Federal jobs in the VA hospital, the Public Health Service hospital, and so forth. The contributions the hospitals can make to a community are legion, not only in the standard training programs for physicians, or nurses, but in these unique training programs. This is because, the PHS hospitals are neutral compared to any other institution located in the community. They are part of a bigger organization. They can afford to be innovative. They can adopt an institutional standard more easily than most institutions. And so they represent a very valuable asset to the community.

Now, the last objection to transferring these hospitals is the effect on patient care. The merchant seaman, as pointed out by Mr. Moody, is a unique patient. He is a transient. And he is a stranger in his own country. He is in and out of ports. He needs service without delay, as Dr. Roy pointed out.

For example, in most of the private hospitals in New Orleans the waiting time for elective surgery now approximates 4 weeks. Not only does this cost the man time, it costs the industry and ultimately the country and the taxpayer money to keep him waiting 4 weeks.

Most importantly, we talk, and I think we honestly mean it, starting with the administration and going all the way down to the local institutions, of trying to remove the barriers to health care. And there are many barriers. They might be economic, they might be ethnic, although those are rapidly decreasing. Sometimes they are political in terms of geographic boundaries or eligibility for care. And yet what we do when we transfer these hospitals, I think, inescapably, we erect new barriers.

In the first place, instead of going one place, the average patient is going to have to go to several places. In the case of Department of Defense dependants, they are going to have to spend more money. All of these present practical barriers, regardless of how much we would wish they did not. There is no question that would interfere with the breadth and depth of health care that these people are getting.

Now, I have difficulty in terms of some of the previous discussions on census, frankly, because, as I said, the American seamen are a unique group, they need the specialized type of facilities and care ready for them. But the other thing is that if we look to the Emergency Health Personnel Act, to the partnership for health law, section 328, these hospitals could in truth take care of the medically indigent or under various types of arrangements with exchange of services, programs, facilities, equipment. It is an almost unlimited opportunity.

With these two legislative authorities, with the dollar multiplier effects and the team backup that I mentioned, we could have an immediate impact on the health needs of the 38 cities in which PHS hospitals and clinics are located. The concept of closure or transfer of these facilities to non-Federal auspices represents a philosophy which will discard an invaluable resource which is potentially far more valuable than anything we can really envision, and provide at best the same, and in truth probably less services, at twice the cost.

Thank you Mr. Chairman.

Mr. Rogers. Thank you, Dr. Walsh, for an excellent statement, in fact, I think perhaps the most comprehensive statement I have heard in summing up what really ought to be the thrust of the Public Health Service.

I wish the Secretary of HEW had been here, and his assistant for Health and Scientific Affairs, as well as the director of the Office of Management and Budget, Mr. Shultz.

I am going to take your testimony and have it abstracted and send it to each of those and ask that they personally read it. I think it will be enlightening for them.

Dr. Carter?

Mr. Carter. Certainly the distinguished gentleman has made an excellent statement. Many aspects, in fact most aspects of it are highly visionary. They are things that might be done and perhaps should be done. In arriving at the conclusions which you would have us arrive at would require different legislation, of course, with respect to our hospitals.

A very good statement.

Dr. Walsh. May I respond to that, doctor?

Mr. Carter. Yes.

Dr. Walsh. Obviously I do not think they are visionary. I do not think any additional legislation is necessary. I think all of these things that I mentioned are currently authorized by existing legislation.

I would point out this, that the National Center for Health Services Research Development, Dr. Santasaro's shop, is that organization in HEW which is concerned with health service research development. This is the one area that is the least controversial in the terms of needing more support.

I am on one of the study committees for that institute which promulgates to, conducts and evaluates research in the organization and delivery of health services. In truth we could spend much more, well, virtually all of the money is being spent on individual projects in many institutions, many hospitals, many organizations. And so what we are doing, then, is spending money for pieces, small pieces. It is my contention that for a relatively modest investment the Federal Government can in effect have maybe four, maybe five institutions which are primarily concerned as much with patient care as with research in the organization and delivery of health care. Such research has to be done, it is being done, but not to the extent that it should. And frankly, there is no one that can do this, other than the Federal Government, as promptly, nor on as broad a scale, with as quick results.

Mr. Rogers. Mr. Preyer?

Mr. Preyer. Thank you, Dr. Walsh, I have found your testimony very interesting. You throw off ideas like sparks from an emery wheel. It is tempting to go into each one of them in more detail. But in the interest of time I hope we can get you back again some time. Thank you very much.

Dr. Walsh. Thank you.

Mr. Rogers. Dr. Roy?

Mr. Roy. I want to congratulate the gentleman on his statement, and thank him for being here. I share the feelings of the other gentle-

men on the committee, that you have presented a number of things that we need to consider.

Dr. WALSH. Thank you.

Mr. ROGERS. Thank you very much. We appreciate your help, Dr. Walsh.

The committee's distinguished witness now is Mr. John F. Griner, who is the national president of the American Federation of Government Employees.

The committee is honored to have you with us. And we shall be pleased to receive your testimony, Mr. Griner. We appreciate your patience in sitting with us during this hearing.

STATEMENT OF JOHN F. GRINER, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ACCOMPANIED BY JOSEPH GLEASON, NATIONAL VICE PRESIDENT; AND PETER RUSSO, PRESIDENT, NEW YORK HOSPITAL LOCAL

Mr. GRINER. Thank you, Mr. Chairman. And frankly, I am honored to be able to appear before this committee.

And with your permission I would like to have the president of our hospital local in New York, who happens to have been the president for a period of 24 years. Mr. Peter Russo on my left, and on my right the national vice president in the New York area, Mr. Joseph Gleason.

Mr. ROGERS. We welcome both of you gentlemen to the committee.

Mr. GRINER. Mr. Chairman and members of the committee. I come before you in a matter of extreme concern to our own union members and of great agitation to the American public as a whole. That subject is the administration proposal to close the eight hospitals still operated by the Public Health Service of the Department of Health, Education, and Welfare, as well as 30 clinics located throughout the country. We have a number of direct interests.

First, as a taxpayer, it is obvious because this proposal will harm the relatively high level of medical care still available in the United States despite the strains which have been placed on our medical facilities by changes in our population, by pollution, and by the Vietnam war.

Our direct interest as a union of Federal employees is also obvious. First of all, among the 600,000 Federal employees we represent in exclusive recognition units, there are the large numbers of Federal employees that we represent in these Public Health hospitals who have dedicated their careers to the provision of hospital care to approximately one-half million patients who annually use these hospitals.

We have another very direct interest because these hospitals provide care for many disabled career Federal employees injured while at work who are directed to these hospitals by the Bureau of Employees' Compensation of the Department of Labor.

QUESTIONABLE LEGALITY OF THE ADMINISTRATION PROPOSAL TO LIQUIDATE THE PUBLIC HEALTH SERVICE SYSTEM

As a union believing in, and relying on, orderly government, we are extremely concerned about the manner in which the administration seeks to achieve the liquidation of these hospitals and clinics. In fact,

we believe the procedure is illegal, and I would like to refer you to the opinion of the Comptroller General, which I believe verifies our contention.

The origins of the Public Health Service system go back to the 18th century. On July 16, 1798, Congress wrote, in the Marine Hospital Act of that year, the basic legislation for the Public Health Service system, codified then at 1 St. 605. The legislative history of that act, as found in the Annals of Congress for the years 1797–99, volume 2, pages 1386–1392, shows clearly that our 5th Congress intended a system of hospitalization available to American seamen using American ports. When the law regarding this system was revised in the Public Health Service Act of 1944, 42 U.S.C. 201, Congress reaffirmed that legislation, supplementing it with other statutory requirements placed on the Public Health Service system.

In 1967, these requirements were further expanded. Consequently, the Congress of the United States, throughout 150 years of legislative action, has clearly expressed the statutory requirement that this service be maintained.

As the 1965 hearings before the House Committee on Government Operations clearly show, the Federal Government is free to open or to close individual Public Health Service hospitals and clinics, as the needs of these ports and cities change, but it cannot legally liquidate the system as a whole, either directly by simple closure or indirectly by transferring its obligations to the Veterans' Administration or to municipal governments.

The administration has tried to invoke the provisions of the Federal Property and Administrative Services Act of 1949, 40 U.S.C. 472(e) dealing with the disposal of excess property as its jurisdiction for closing the hospitals and clinics. I have had that act studied closely and I am convinced that the congressional intent behind it is limited to disposing of excess properties which are surplus to the performance of the actual mission of an agency and in no way a legal basis for liquidating the statutory mission itself which has been imposed by Congress. If a hospital or clinic here or there has excess property, it can, of course, be sold or liquidated. But the Public Health Service itself cannot be.

CLOSING THE HOSPITALS AND CLINICS WILL NOT REDUCE BUT INCREASE COSTS

The administration has asserted that the American people have the right to expect that their Government will protect them against the consequences of illness, injury, and disease. It has also recognized that they have the right to expect that their Government will protect them against the consequences of illness, injury, and disease. It has also recognized that they have the right to obtain the protective service now, not tomorrow—efficiently, quickly, and at a minimum cost. Consequently we find it inconsistent and contradictory that the administration is proposing dismantling hospital services already available.

The administration has not contended, of course, that there are no patients using these hospitals or the 30 associate clinics throughout the United States. It has argued instead that their closing will result both in savings of money and in better medical services to present utilizers of these hospitals and clinics.

The facts contradict these arguments sharply and decisively.

First of all, there would be no savings realized. The Federal Government's own statistics show that the average cost per patient for the one-half million patients using these hospitals is $58 per day, ranging from $45.33 in New Orleans to $79.52 in Baltimore. In the immediate vicinity of the urban centers where these hospitals are located, the average daily cost of hospitalization is already approaching $100 a day. Here in Washington, D.C., Baltimore, Md., and in New York City, it already exceeds $100 per day. Thus, we could easily expect that the closing of these hospitals will immediately cost the Federal Government at least $20 and perhaps as much as $35, more per patient per day. I estimate this to be approximately $15 million per year at the minimum.

Mr. ROGERS. If I might interject there, Mr. Griner, the figure you quoted for the Public Health Service, the $58 average, also included the physician's costs, which are not included in the $100 a day.

Mr. GRINER. That is right, sir.

Mr. ROGERS. So it would even be more?

Mr. GRINER. That is right, sir.

Second, these half million patients will need to go to other hospitals, already overburdened by the demands on their facilities. This will raise costs and impose cruel physical and mental hardships on such patients as injured seamen; disabled retired Federal employees; and members of the Coast Guard; and the indigent and sick of the communities where these facilities are located and which now admit them at reasonable rates.

I can envisage these people going from hospital to hospital, traveling long distances in pain, simply because their Government was so busy dreaming about a good and universal health program for the future that it decided to ignore the present.

Besides these immediately evident increases in hospitalization costs, there will be a further impact on the entire merchant marine economy. Today, seamen can enter these hospitals on a priority basis. They can receive speedy treatment for injuries and illnesses. Thus they can return to their jobs aboard ship in a relatively short time, without loss of pay to themselves. Moreover, the American merchant marine, already under serious competitive pressure from foreign lines, is assured that it will have available at all times competent and skilled seamen to man the ships without excessive labor turnover due to illness or injury. The savings of pay to seamen and the savings of expense to the American merchant marine alone fully compensate our country for the existence of the Public Health Service hospital and clinic system.

As the administration claim that the hospitals of the Veterans' Administration can economically take care of the seamen and the other present beneficiaries of the Public Health Service system, I believe that it is clear that the Veterans' Administration must by law give priority to veterans. Seamen, disabled nonveteran Federal employees and other beneficiaries would just have to wait at the end of a long line for hospital space of the Veterans' Administration or resort to private health care at a much higher cost.

Mr. Chairman, we represent the employees in approximately 100 Veterans' Administration hospitals. I do not know of a single Veterans' Administration hospital that today does not have a long waiting

line of people who want to get in, sick or disabled veterans who want to get into those hospitals for medical care. Of course, they take the emergency cases. But sometimes these people have to wait for weeks and months. It is almost unconscionable to even have a thought that the Veterans' Administration can take care of the people who now use the Public Health hospitals when they cannot take care of their own.

THE VALUE OF THE HOSPITALS TO MEDICAL SCHOOLS AND TO MEDICAL RESEARCH

Besides the sick and the needy who depend so heavily on these facilities, other American citizens are greatly indebted to them for providing the training facilities for students at medical schools, interns specializing in selected disabilities, and laboratory and nursing technicians. If the hospitals had not provided any other service to their country, it must be recognized that they have been the training facilities for thousands of doctors and nurses who now serve the sick and the wounded on the battlefield of Vietnam; in the emergency operating rooms of private hospitals; in the lecture rooms of universities; and in the overcrowded wards of the Department of Medicine and Surgery of the Veterans' Administration, where thousands of our veterans receive the care which their Nation owes to them.

Let us look at the role these hospitals play today in training those medical and surgical doctors, nurses, and technicians on whom all of us, including the administration, are counting to provide the services of the future.

The Seattle hospital is a typical example. And I was very pleased to hear the dean of the Washington Medical School this morning, what he had to say. Like several others, it is an integral part of the teaching facilities of a medical school—in this case the University of Washington. Were that hospital to close, the university's efforts to increase the education of much-needed doctors would be seriously impaired.

The integration of facilities in Seattle are so complete that the director of the Public Health hospital is also the assistant dean of the medical school. In a statement to the press, Dr. Willard Johnson, the director, said the following:

"All our senior staff, our full-time people, are public service officers and most of our interns and residents are also in the commissioned corps. Besides, this is where Seattle University sends its nursing students for clinical experience. The director of that program tells me they would really be at a loss to find another hospital for this purpose if this one should go.

To demonstrate the magnitude of this interrelationship, I request permission to insert into the record of my testimony here a table of statistics which appears as an annex to my statement concerning the Public Health Service Hospital in Seattle, Wash., and the numbers of medical students, student nurses, and student technicians associated with its operations.

Mr. ROGERS. Without objection it is so ordered. (See p. 363.)

Mr. GRINER. In Galveston, Tex., the University of Texas Medical School branch depends on the Public Health Service hospital there. In New Orleans, Tulane University's Medical School similarly depends on the Public Health Service hospital there.

The Public Health Service hospital in San Francisco serves as a training center for the University of California, Stanford University, and for San Francisco City College. In addition, it provides needed medical support for the NASA space program, as well as treatment for Federal disabled employees sent there by the Bureau of Employees' Compensation. Altogether 120,000 individuals receive patient care there annually, with the largest number being seamen, Coast Guard and Geodetic Service personnel, and active and retired military personnel.

On Staten Island, the location of the Public Health Service hospital for New York City, three colleges offering premedical studies would be seriously affected if that facility were closed. These are Richmond College, Wagner College, and Staten Island Community College. The closing would also hinder operations at Willowbrook State School, which sends its practical nurses to the hospital for clinical and bedside training.

Similar situations exist for the other three hospitals in Baltimore, Boston, and Norfolk.

Since first making its proposal to close these eight hospitals and 30 clinics outright, the administration has modified its public posture somewhat by stating that it did not intend to close the facilities but merely to transfer them to the governments of the cities in which they are located.

We welcome this most recent admission by the administration that the hospitals are needed. But we see no merit in the proposal that they should be transferred to municipal authorities. We all know that the financial budgets of all cities are so strained that the administration itself is speaking of "tax sharing." Let us frankly realize that the cities are not able to absorb these additional responsibilities when they can scarcely keep up with the economic and financial challenges they already face.

Quite frankly, our union has been most surprised that this and the past administrations have allowed a situation to develop where these hospitals have become as "run down" as they are today. I recall myself that when the basic subject of these hospitals was last before Congress in 1965, the Deputy Assistant Secretary of HEW, Mr. James F. Kelley, gave assurances that appropriated funds would be expended to improve hospital facilities, providing for "overall modernization and expansion." Yet despite congressional commitments to improve the facilities, the executive branch has ignored these mandates to carry out necessary improvements and now once again comes up with proposals to destroy this vital Federal function.

Mr. Chairman, this has happened time and time again. The administration is trying to do indirectly what Congress refused to let it do directly by permitting these hospitals to dry up.

I heard a statement this morning that modernization of these hospitals would cost from 90 percent to 100 percent of the cost of new facilities. In 1965 certainly it would not have cost that. That is almost 6 years ago. Costs were different then than what they are today.

But I think there has been a determined effort on the part of the past administration as well as this administration to dry up these hospitals in any way possible by not furnishing sufficient personnel to operate them, and by overloading the personnel that they do have

there. And as a result they come before you now and say, it is cheaper for us to contract. That is what they want to do, is to contract this work out at a cost far greater than what it would cost to do it in-house. It is cheaper to contract this work out to the city, to the Veterans' Administration, or some other place. And we know we cannot do it with the Veterans' Administration. In other words, the old question of contracting out, which this organization loathes, comes into play again in this case.

Rather than closing down facilities, I recommend an immediate expenditure of funds to make up for the omissions of the past. The facilities should be modernized and any spare space that is available should be converted immediately to solving the increasing narcotic and alcoholic addiction problems that confront our country. These facilities are located in major ports of the United States where problems of addiction are most acute and where the cures are most needed.

The marvelous facilities in specialized research which the medical schools and faculties have developed in these hospitals are a national treasure. As late as January 3, 1971, President Nixon himself signed into law the Health Manpower Shortage Act calling for, among other things, the expansion of the U.S. Public Health Service's elite corps of career medical officers and programs. These programs include the superlative cancer research project in the Public Health Service hospital in Baltimore which works closely with the National Cancer Institute in Bethesda, Md. Other advanced research programs relate to cardiovascular malfunctions, pulmonary ailments, muscular atrophy, and occupational diseases, especially those connected with the sea.

THE OBLIGATIONS OF THE FEDERAL GOVERNMENT AS EMPLOYER

Up till now I have dealt with the general public issues involved in the administration proposal to liquidate the Public Health Service hospitalization system. I have challenged that proposal on legal, financial, and professional grounds.

As a representative of the employees of that system, I wish now to challenge it also on the grounds of proper employer-employee relationships. After all, that system has been operated for over 150 years on the basis of the loyal service of a staff of career Federal employees now numbering several thousand. Like other Federal employees, they are entitled to due consideration in matters affecting their careers.

The 1972 budget of the Department of Health, Education, and Welfare for the Public Health Service shows a drop from 6,252 in fiscal 1971 to 970 employees projected in fiscal 1972, or a decline of 5,270 employees.

I have not heard, or read, a single word as to how the Department of Health, Education, and Welfare proposes to show due consideration to these 5,270 loyal Federal employees, some of whom have served the Public Health Service system during their entire Federal career, or their working life.

We know that altogether the Federal Government has under its immediate jurisdiction hospital facilities in the amount of over $2.1 billion of appropriations annually. We know that collectively, the Federal hospitals of all types have more than 175,000 hospital beds. The Public Health Service hospitals have approximately 2,500 hos-

pital beds, of which approximately 1,500 are filled daily by seamen. What plans has the Department of Health, Education, and Welfare developed to take care of its present employees whom it intends to deprive of their jobs by closing eight hospitals and 30 clinics?

Are they simply to be fired or retired if they are eligible for retirement?

In those cases where they had not yet earned enough retirement credit to warrant an immediate retirement annuity following the abolition of their jobs, has HEW arranged to have them transferred to other Federal hospital systems? Has there been, in fact, any discussion at all by the Department of Health, Education, and Welfare with the White House, the Office of Management and Budget, or the Civil Service Commission or the unions which represent these employees on job security?

In the name of the Federal employees who would be affected, I earnestly ask your subcommittee to ascertain the steps which the Department of Health, Education, and Welfare has taken on their behalf as career employees losing their jobs.

I might state that to the best of my knowledge—and I think I have got a pretty good grapevine system—there has not been one single word, or one single expression made by any of these groups that I have just named as to what they intend to do with these Federal employees. In other words, they forget the human side altogether. They are trying to put the dollar mark before human misery.

SUMMARY AND CONCLUSION

In summary, I wish to stress that the administration proposal to close, or even to transfer to municipal governments, eight Public Health Service hospitals and 30 clinics is, in my very deliberate opinion, illegal and a violation of the will of Congress as expressed in 150 years of legislation.

Additionally, I wish to record my concern that this decision seems to have been taken without any consideration being given, either from the legal or the humanitarian standpoint, to the welfare and the careers of thousands of loyal employees of the Public Health Service system.

These facts alone justify suspending all further actions to liquidate these hospitals and clinics as Federal enterprises. Besides, if they were to be closed, the result will be only to harm the relatively high level of medical care now available to urban populations in American ports. It will likewise adversely affect the medical training programs of medical schools, universities, and colleges educating our future doctors, nurses, and medical technicians. Also harmed will be specialized research programs, especially in cancer and in cardiovascular diseases.

Although the decision to close or transfer these facilities is alleged to be financial, no money would be saved if they shut their doors. Instead, costs will rise and the patients will be subjected to serious inconvenience and even to danger to health in seeking other facilities for the cure of their illnesses.

Instead of closing or transferring hospitals, the Federal Government should modernize them and use them to launch new programs for the treatment and cure of narcotics and alcoholic addicts.

Furthermore, the Public Health Service facilities should be regarded as an integral part of the national health care system to which our Nation is now dedicated and which the Congress is now developing.

In conclusion, I wish to express once again my appreciation for the opportunity to testify. Our organization strongly endorses House Concurrent Resolution 98 and I pledge you our fullest cooperation in achieving the noble and practical goals it outlines.

Thank you, Mr. Chairman.

(The annex to Mr. Griner's statement, referred to, follows:)

ANNEX—RELATING TO THE U.S. PUBLIC HEALTH SERVICE HOSPITAL, SEATTLE, WASH.

(1) Patient Care—7/69–6/70.
Bed capacity: 262.
Admissions: 5,110.
Average daily census: 180.
Average occupancy: 68%.
Outpatient visits: 110,000.
Expense: Total=$7,737,479; Payroll=$6,308,000.
(3) Personnel:
Civil Service Employees: 396.
Paramedical: 492.
Physicians and Dentists: 147.
(Staff and Residents).
Training Programs:
Graduate Medical and Dental—University of Washington.
Interns: 17 Medical, 6 Dental.
Residents: 36 Medical, 4 Dental.
Fellows: 4 Medical.
Undergraduates: 85—or 25% of the entire medical class.
Nursing Students: 60/year from Seattle University.
Physical Therapy: 31/year from University of Washington.
Occupational Therapy: 2/year from University of Washington.
Dental Hygiene Students: 25/year from University of Washington, 29/year from Seattle Community College, 24/year from Shoreline College.
Pharmacy: 2 Residents and 8 students from University of Washington.
Medical Technology Students: 21/year from University of Washington.
Miscellaneous Students:
Medical Records Technicians—4/year.
Medical Records Librarians—8/year.
Ward Clerks—6/year.
Operating Room Technicians—3/year.
Research programs totaling $1,200,000 would have to be re-located if hospital were to close.
Miscellaneous employees:
Manpower—3.
Work Incentive—15.
College Work Study—15.
Neighborhood Youth Corps—11.

Mr. ROGERS. Thank you, Mr. Griner, Mr. Russo, and Mr. Gleason. We are grateful for your being here. And I think you have brought out some points that had not previously been brought out.

They made no public announcement as to what they would do with these employees.

Mr. GRINER. Nor private that I could find out.

Mr. ROGERS. And certainly we shall go into this and pursue this question. And your testimony has been very helpful.

Mr. GRINER. We are just as close as the phone.

Mr. ROGERS. Thank you. We appreciate your being here.

Mr. GRINER. Thank you.

Mr. ROGERS. Our next witness is Mr. William Hiscock of the Baltimore Planning Commission.

Mr. Hiscock, we welcome you to the committee.

If you have a prepared statement we would be glad to make it a part of the record.

STATEMENT OF WILLIAM McC. HISCOCK, DIRECTOR OF HEALTH PLANNING, REGIONAL PLANNING COUNCIL, AND PRESIDENT-ELECT, ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES

Mr. HISCOCK. Yes, sir. I just want to touch on two points from the viewpoint of areawide health planning. And we are very mindful of the chairman's sponsorship of health planning.

I wish to speak first for the Regional Planning Council in Baltimore, on the hospital in Wyman Park. And the second brief statement I would like to make, sir, speaks for the Association of Areawide Health Planning Agencies across the land.

I realize the hour is late.

Mr. ROGERS. You may proceed.

REGIONAL PLANNING COUNCIL STATEMENT

Mr. HISCOCK. Very briefly, the regional planning council was established by the Maryland General Assembly in 1963 as a cooperative planning body for Metropolitan Baltimore, an area of about 2,200 square miles, in which 2 million persons reside. The majority of our governing body are local elected officials from the area's six major jurisdictions—Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties.

The regional planning council has been designated by the local community, the State of Maryland, and the U.S. Department of Health, Education, and Welfare as the region's areawide health planning agency. This responsibility is carried out in joint effort with a broadly representative citizens health council which involves the general public and the many and varied individuals, and private and public organizations providing health service in the area.

Our planning strategy and style is to involve those affected and those who can affect health planning decisions. And we view Federal resources, including the Public Health Service Hospital in Wyman Park, as regional resources. The PHS Hospital and neighboring communities have interacted in mutual planning, and have related their planning to community health planning. Thus, we were very much concerned when the precipitous closing of PHS hospitals and clinics was first rumored last December.

Essentially our position is to support the continuation, and indeed, the strengthening of these resources.

We feel that the role and function of these resources should be determined in good part in the context of the health needs and strategies of the communities in which they are located. We also suggest that the role and function, and needs and strategies, will be different from one community to another.

In our community, Metropolitan Baltimore, we have found that with a relatively small Federal investment, the PHS hospital in Wyman Park has already demonstrated itself to be a critical catalyst for innovative manpower. It serves at least 30 major training programs, from junior high school, school dropouts getting back on the career ladder, all the way up through postgraduate medical education.

In January we assisted in the factfinding team's review, and held an evening session, which demonstrated a very unique coalescence of State and local legislators and executives, neighborhood groups, neighboring hospitals, medical societies, and hospital associations. Congressman Sarbanes also participated in that session. The coalescence was around the point mentioned above: The demonstrated and potential ability of PHS to assist in solving health care problems in the community.

Now, as in most metropolitan areas, primary ambulatory care is a principal deficit. Should the hospital close as previous speakers have mentioned, this deficit would be magnified for the Federal beneficiaries for whom the hospital now provides a continuity of care. On the other hand, a programed extension of the facilities as a community resource could assist in meeting that deficit for a significant portion of our area. And that extension as a community resource does not necessarily imply a change in ownership or operation of the facility. In other words, the authority to be a community resource under HEW management, as Dr. Walsh mentioned earlier, is there.

In short, we suggest an alternative in which the Federal partners join with us, in areawide health planning in Baltimore, to focus on the twin problems of care for the beneficiaries, and the function of the Public Health Service hospital. However, in our judgment if such a course is followed, it requires at least four actions:

First, a declaration of intent, which is loud and clear from HEW—from the Federal Government—that such a course will be followed. This will prevent any loss by attrition of the staff, and the staff in any institution is the critical component.

Second, a commitment, supported by the Congress, to work through the inherent issues.

Third, the encouragement of the facility and its staff to continue and extend its community service functions.

Fourth, recognition by the administration and the Congress of the capital and operating costs involved, which were spoken to so eloquently by the preceding witnesses.

In summary, Mr. Chairman, the members of the regional planning council and the Citizens Health Council are pleased to be here to present our thoughts to you. We are encouraged by your committee's interest, and of course the interest shown by the Maryland delegation. And we stand ready to assist you in any way in developing a positive resolution of this problem.

ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES STATEMENT

My second statement, sir, is in behalf of the Association of Areawide Health Planning Agencies, which I am privileged to serve as its president-elect.

The association is a voluntary association of close to 100 local community or regional health planning agencies across the Nation; and includes most of those agencies which receive some form of support under section 314(b) of the Public Health Service Act. Our members serve seven of the communities in which Public Health Service hospitals are located:

Boston: Hospital Planning for Greater Boston.

Baltimore: Regional Planning Council, Baltimore.

New Orleans: New Orleans Area Health Planning Council.

New York: Health and Hospital Planning Council of Southern New York and the City of New York Health Planning Organizational Task Force.

Norfolk: Tidewater Regional Health Planning Council.

San Francisco: Bay Area Comprehensive Health Planning Council.

Seattle: Puget Sound Comprehensive Health Planning Board.

Mr. Chairman, our message is brief. In this time of national health care crisis and transition, we urge the Federal partner to join us in areawide health planning to tackle the two problems of:

(1) Delineating the future role of the PHS hospitals; and

(2) Meeting its responsibility of care for Federal beneficiaries.

We believe that such issues can and should be faced on the ground, in the communities affected. We believe also that rational and well-developed strategies for health care improvements can be developed there by the Federal and community parties acting openly and in concert. Commitment to take on such a job is a necessary first step. This association, particularly its members in Baltimore, Boston, New Orleans, New York, Norfolk, San Francisco, and Seattle, stand ready to assist in achieving that end.

Mr. Rogers. Mr. Hiscock, I appreciate that. And I think it would be meaningful for the committee to know of the commitment of the organization you represent. We are hopeful that something can be done. Certainly the proposed action and the way they would have to handle beneficiaries, and so forth, would cost more to the Government than maintaining the system. And the rationale is very difficult to understand.

Mr. Hiscock. At the present time we have quite an uncertain situation, sir.

Mr. Rogers. We are going to try to settle that, we hope. Thank you very much.

Our last witness is Dr. Edward Hinman, who is the medical officer in charge of Baltimore Public Health Service Hospital.

Doctor, we appreciate your being here, and I am sorry that we have had to hold you such a late time to testify.

STATEMENT OF DR. EDWARD J. HINMAN, DIRECTOR, PUBLIC HEALTH SERVICE HOSPITAL, BALTIMORE, MD.

Dr. Hinman. Thank you, Mr. Chairman.

I am Edward Hinman, commissioned officer in the U.S. Public Health Service. Since January 1, 1968, I have been privileged to be the director of the U.S. Public Health Service Hospital in Baltimore, Md.

I would be happy to answer any questions that you may have.

Mr. Rogers. Thank you.

What I would like for you to do is to outline for the committee what you are doing, the size of your hospital, the number of people there, the staff, and the number of people trained there.

Dr. HINMAN. The Baltimore PHS facility was constructed in 1932 as a 300-bed general, medical, and surgical hospital. Due to the changing nature of health care delivery our inpatient census has decreased with time. At the present time we have operating 288 beds. We operate all clinical services as an inpatient function except obstetrics and pediatrics, obstetrics because we have never had that service at the hospital and have never had need to because of available community resources. There was a pediatrics ward that we once operated as an inpatient service, but because of declining occupancy rates and staffing problems we found it necessary to close that service approximately a year and a half ago.

We have a total staff of approximately 650 employees. Of these, 150 are commissioned officers, and 500 are civil service personnel.

As previous witnesses have testified, our physicians are all full-time employees of the hospital. We have all specialties represented except obstetrics. We do have consultants from both medical schools, numbering in total 90, who regularly come to the hospital throughout the year to advise us in areas where we may wish additional consultation or teaching services.

Service of course is the prime responsibility of any hospital. We provide service to primary beneficiaries, secondary beneficiaries, and on a space available basis to community individuals who do not have available medical care. For the last year and a half we have admitted patients from accident rooms of community hospitals when there were no beds available to them so that they would not be turned away. I will be glad to supply further information regarding services provided by our hospital.

Mr. ROGERS. That will be fine.

(The following information was received for the record.)

SERVICES PROVIDED BY THE U.S. PUBLIC HEALTH SERVICE HOSPITAL, BALTIMORE, MD.

This hospital's primary mission is to provide comprehensive medical care to legal beneficiaries on an outpatient and/or inpatient basis. Non-legal beneficiaries are also cared for as "emergencies" and "special study" patients. Emergency cases include patients with heart attacks brought to this hospital by the Baltimore Fire Department ambulance and "overflow" medical cases seen in the Emergency Rooms of five community hospitals.

Medically indicated care for patients is provided by a staff fully organized into twelve clinical departments, eight para-clinical departments and six administrative sections, all under the leadership of the Director of our hospital. In addition, a Dental Department provides indicated dental care, including oral surgery, to eligible outpatients and/or inpatients.

Plans have been made to extend our comprehensive medical care facilities into the Homestead-Montebello area, in which there is a population of some 30,000 with no practicing physician, as an experimental module to study the problems involved in establishing heretofore non-existent health centers in such communities. Lacking official approval, implementation of our plans have not been possible to date.

Concurrent with the medical care program are fully accredited programs in training in the health care field and medical research. Training programs include residency training programs in seven medical specialties, dentistry, hospital pharmacy and hospital administration, fellowship training program in cardiovascular medicine, internship training program in medicine and in dentistry, medical student affiliation training programs with both the University of Mary-

land and the Johns Hopkins University, graduate nursing student training program with the University of Maryland, nursing student affiliation training programs with both Catonsville and Baltimore Community Colleges, nurses' aid training program operated in conjunction with the Baltimore City Adult Education Division and physical therapy student affiliation training program with both the University of Pennsylvania and University of Maryland. Moreover, there is a School for Medical Technologists and the only federally operated School for Medical Record Librarians is located in this hospital.

Research projects are directed from three different approaches. First, our Clinical Investigations Department conducts cardiovascular research and has in operation a complete and modern cardiovascular catheterization and angiography laboratory. It also operates a Heart Disease Prevention Clinic to survey some 16,000 employees at the Headquarters of Social Security Administration in Baltimore and supports research in other departments of our hospital. Our annual report for calendar year 1969 lists fourteen research projects being carried out by this department.

Second, the Baltimore Cancer Research Center of the National Cancer Institute is located in this hospital and conducts clinical evaluation on chemotherapeutic agents used singularly or in combination in certain malignancies. It carries out laboratory programs in drug research, biochemistry and immunology seeking basic information on the problem of cancer and its control. Our annual report for calendar year 1969 lists 28 research projects being undertaken by our Baltimore Cancer Research Center.

Third, our Health Services Research Department conducts research in physical layout, design and utilization of medical care delivery systems, operations research, application of computer systems and evaluation of administrative policies. This department utilizes our hospital as a manageable and controllable environment to find solutions to problems. Almost all of this department's 28 research projects listed in our calendar year 1969 annual report have to do with the planning and development of our Health Evaluation Center which administers a battery of rapid screening tests on a mass basis to identify unrecognized diseases or defects.

Altogether 75 scientific papers have been completed as a result of research studies conducted during calendar year 1969 and are listed in our annual report for that year.

Number of beds available to the hospital over the past five years

Fiscal year:	
1966	300
1967	300
1968	261
1969	261
1970	238

Size of staff each year beginning in 1965

Fiscal year:	
1966	529
1967	575
1968	622
1969	644
1970	645

Average length of stay for hospital patients

Fiscal year:	*Days*
1966	20.2
1967	18.9
1968	18.4
1969	15.7
1970	15.3

INPATIENT WORKLOAD

	Calendar year—		
	1968	1969	1970
Total inpatient admissions	4,429	4,376	4,084
Admissions by beneficiary:			
Seamen	1,147	1,060	981
C.G. and N.O.A.A. (ESSA)	587	618	681
PHS	152	96	107
BEC	121	94	91
Special study	847	955	880
Other nonreimbursable	6	16	9
Dependents	1,020	972	702
DOD	397	418	421
FS	64	72	62
Other reimbursable	88	75	150
Clinical service admissions	4,429	4,376	4,084
Medicine	1,318	1,403	1,430
Psychiatry	75	49	90
Surgery	870	893	660
Orthopedic	322	320	354
Urology	261	253	216
Ophthalmology	258	242	246
Otolaryngology	306	376	309
Tumor	709	540	500
Pediatrics	82	39	1
Dental	228	261	278
Total patient days	79,683	65,744	61,644
Average length of stay (days)	17.8	14.9	15.1

OUTPATIENT DEPARTMENT CLINIC VISITS

Cardiology	681	3,213	5,446
Dental	8,552	9,105	10,056
Dermatology	1,137	2,511	2,033
Thyroid	506	452	398
Surgery	3,814	4,278	4,151
Gynecology	1,314	1,456	1,121
Medicine	5,439	4,809	6,121
Ophthalmology	10,102	9,730	10,753
Orthopedics	3,744	3,228	3,701
Otolaryngology	3,664	3,577	3,661
Pediatrics	7,649	8,752	10,124
Psychiatry	1,147	1,001	1,687
Tumor	2,641	2,060	2,224
Urology	2,059	2,075	2,318
General	34,552	35,430	39,247
Total	87,001	91,677	103,041
Physical therapy	4,535	6,823	7,267
Occupational therapy	18	76	86
Nutrition	260	326	548
Nuclear medicine and radiation therapy	633	1,780	2,454
Grand total	92,447	100,682	113,396

OUTPATIENT VISITS BY BENEFICIARY

Seamen	17,574	16,713	17,357
C.G. & N.O.A.A. (ESSA)	4,127	3,668	4,979
PHS	2,323	2,174	3,016
BEC	3,460	3,627	4,286
Special study	4,836	5,118	6,794
Other nonreimbursable	5,778	7,620	10,462
Dependents	35,166	35,414	46,407
DOD	10,363	11,370	15,380
FS	323	295	233
Other reimbursable	640	859	1,445
Total	84,590	86,858	110,359

U.S. PUBLIC HEALTH SERVICE HOSPITAL, BALTIMORE, MD.

Category of expense	Annual budget for fiscal years— 1968	1969	1970
Personal services and benefits	$4,800,642	$5,261,365	$5,699,259
Equipment	236,867	152,093	144,738
Maintenance and repair	47,800	118,900	212,000
Supplies and other contractual	635,128	703,784	773,474
Subtotal	5,720,437	6,236,142	6,829,471
Collaborative research, N.C.I.	1,313,000	1,330,000	1,366,000
National Institute health grants	91,607	105,300	98,351
Lipid laboratory			41,500
Health evaluation and research	174,059	245,459	569,382
Total allocation	7,299,103	7,916,901	8,904,604

COST OF HOSPITAL STAY FOR EACH TYPE OF PATIENT

Fiscal year	Actual per diem cost [1]	Charge to other Government agencies [2]	Foreign seaman [2]	Emergency pay patient [2]
1966	$32.67	$27	$42	$42
1967	37.52	27	42	42
1968	42.33	27	42	42
1969	55.49	33	49	49
1970	79.52	33	49	49

[1] This is the rate that would be charged to nonpay beneficiaries (e.g. American seamen, Coast Guard, PHS officers, etc.) if they were required to pay.
[2] Rate set by the Bureau of the Budget.

Note: These rates are all inclusive (physicians, consultants, and all other necessary services). In addition to the inpatient operation of this hospital, we have over 100,000 outpatient visits per year.

Dr. HINMAN. Our training programs are extensive. We have 32 physicians in residency training programs representing seven specialties, viz, internal medicine, surgery, radiology, pathology, otolaryngology, ophthalmology and preventive medicine.

We have two types of medical internships: a rotating internship and a straight medical internship, with 10 interns currently in training.

We have a dental general practice residency with two residents, and a dental internship program with three interns.

And we have a pharmacy residency training program. Incidentally, the pharmacy residency is in hospital pharmacy and approximately a quarter of such residencies throughout the country are in Public Health Service hospitals.

We have paramedical training programs. We have a school for medical technologists. We have the only school for medical records librarians in the State of Maryland, and until this last year it has been the only Federal school in the country for medical records librarians.

We are training other paramedical personnel. We have physicians assistants from community university on an affiliated basis. We are training other types of physicians assistants, nontechnical assistants and technical assistants, ranging everywhere from the antipoverty program, the neighborhood youth program, and college students up through medical students, nursing students, dental students, pharmacy students, and others.

We have affiliations with community colleges in Baltimore for nurses training, physical therapy assistant training, and occupational therapy assistants training.

And I am sure I have left a few out in going through here quickly. I would be glad to furnish a complete list for the record if you would like to have it.

Mr. ROGERS. Yes.

(The following information was received for the record:)

TRAINING PROGRAMS

I. Administration

A. Bureau of Prisons—Medical Technical Assistants—Administrative Training.

B. Hospital Administration Residency—1 per year.

II. College Work Study—various departments.

III. COSTEP

A. Dental.
B. Dietetic.
C. Medical.
D. Nursing.
E. Pharmacy.
F. Physical Therapy.

IV. Dental

A. Internship—3 per year.
B. General Practice Residency—2 per year.

V. Health Services Research

A. Graduate students from Johns Hopkins University School of Hygiene and Johns Hopkins University, Homewood Campus.

VI. Housekeeping

A. Executive Housekeeper Seminars.

VII. Medical

A. Students—
1. University of Maryland—Physical Diagnosis (Sophomores).
2. University of Maryland—Surgery Clerkship (Seniors).
3. University of Maryland—Ambulatory Care Clerks (Seniors).
4. Johns Hopkins University—Ophthalmology Clerkship (Seniors).

B. Internships—
1. Rotating Medical—approved for 12.
2. Straight Medical—approved for 2.

C. Residencies—
1. Internal Medicine—3 per year.
2. Ophthalmology—2 per year.
3. Otolaryngology—1 per year.
4. Pathology—2 per year.
5. Preventive Medicine—1 per year.
(Affiliated with School of Hygiene, Johns Hopkins University).
6. Radiology—2 per year.
7. Surgery—1 per year.

D. Fellowships—
1. Cardiology.
2. Oncology.
3. Radiology (Clinical Associate).

VIII. Nursing

A. Nurses Aides—MDTA—Baltimore City Department of Education—PHS Hospital—6 mo. program—3 at Hospital—approximately 50 students per year.

B. Associate in Arts—Catonsville Community College—Medical—Surgical Nursing Experience. Baltimore Community College—Medical—Surgical Nursing Experience.

C. Graduate Students—University of Maryland.

D. In Service—LPN Waiver-License Preparation.

IX. Occupational Therapy

A. Occupational Therapy Aides.

X. Personnel

A. Supervisory Management—2 8-hour Seminars.
B. YOC—8 hours of Seminars.

XI. Pharmacy

A. Students—University of Maryland School of Pharmacy.
B. Residents—3 per year.

XII. Physical Therapy

A. Students—affiliating from University of Maryland and University of Pennsylvania.
B. Aides.

XIII. School for Medical Record Librarians—12–15 per year.

XIV. School for Medical Technologists—4–8 per year.

XV. Social Service

A. Alcoholism Counselors.

XVI. Special Services

A. Volunteer Training for youth ("Candy Stripers").

U.S. PUBLIC HEALTH SERVICE HOSPITAL

Baltimore, Md.

AFFILIATED TRAINING PROGRAMS

PHS Hospital, Baltimore, Md	Discipline /speciality.
Baltimore City Health Department, Alcoholism Center	Alcoholism counselors.
Baltimore Public Schools	Nurses aides and/or orderlies.
Bryman School, Towson, Md	Clinical and laboratory experience for medical assistants.
Catholic University, School of Nursing, Washington, D.C.	Nursing science administration.
Catonsville Community College, Catonsville, Md.	Nursing.
Church Home and Hospital, Baltimore, Md.	Medical record librarian students.
Colby Junior College, New London, N.H.	Medical record library science training.
Community College of Baltimore, Baltimore, Md.	Medical record librarian students, physical therapy assistants, nursing.
Crownsville State Hospital, Crownsville, Md.	Medical record librarian students.
Duke University Medical Center, Durham, N.C.	Clinical experience in ambulatory care including multiphasic health testing: Physicians' assistant trainees and graduates.
Gettysburg College, Gettysburg, Pa	Practical experience for medical library students.
Good Samaritan Hospital, Baltimore, Md.	Medical record librarian students.
Greater Baltimore Medical Center, Towson, Md.	Do.
Johns Hopkins Hospital, Baltimore, Md.	Do.
Johns Hopkins Hospital and School of Medicine (department of otolaryngology), Baltimore, Md.	Otolaryngology.
Loyola College, Baltimore, Md.	"Minimester" exposure to application of didactic book learning.
Maryland General Hospital, Baltimore. Md.	Medical record librarian students.
Medical College of Virginia, Richmond, Va.	Hospital administration residency training.

NCI-Baltimore Cancer Research Center, Baltimore, Md.	Collaborative research program in cancer treatment and laboratory investigation.
Provident Comprehensive Neighborhood Health Center, Baltimore, Md.	Medical record librarian students.
St. Agnes Hospital, Baltimore, Md	Do.
St. Joseph Hospital, Towson, Md	Do.
State of Maryland Health Department, Baltimore, Md.	Occupational therapy assistants.
Towson State College, Towson, Md	Collaborative allied health training program.
Union Memorial Hospital, Baltimore, Md.	Medical record librarian students.
University of Alabama, Birmingham, Ala.	Hospital administration residency training.
University of Maryland, Baltimore, Md.:	
School of Medicine	(1) Clerkship in general surgery, (2) Training in physical diagnosis, (3) Senior curriculum in ambulatory care, (4) Clinical internship for graduating physical therapy students.
School of Nursing	Learning experience in care of cancer patients.
School of Pharmacy	Cooperative educational and research programs.
University of Pennsylvania, division of physical therapy	Physical therapy students.

Dr. HINMAN. Our research programs are in three major areas: Health services research, which Dr. Walsh so beautifully described to you, is something which has been an integral part of our hospital for 5 years now. It is not on the drawing board, it is here. We have a staff of 17 full-time professionals with skills ranging from industrial engineering, systems engineers, operations researchers, up through physicians, nurses, pharmacists, et cetera.

The major task that they have performed to date was the design and implementation of our Health Evaluation Center, which is a form of automated multiphasic testing in a hospital setting used as an entry point for patients into health care delivery system.

One of the problems facing professionals in this area is entry into a delivery system. Most people enter via an accident room or via a physician's office referral to a hospital. We feel that patients should be brought to the hospital, examined, and a baseline of information obtained so that the proper treatment can be arranged if there are abnormalities, and so that there may be a baseline of information for further evaluation in subsequent years.

One of the unique features about this Health Evaluation Center is the fact that it operates in an area that during the daytime is used for our general clinics and emergency room. The operating hours are from 4 p.m. to 9 p.m. Monday through Friday. One of the problems facing the hospital administrator is unused space during off duty hours. And we have compensated for this in one area, which in the long run should lead to some cost containment.

Other programs that our Health Services Research Department has been involved in include task analysis of various professional tasks,

evaluation of certain types of hardware that might be used in hospital settings, and I can furnish for the record a complete listing of some of the projects that they have engaged in in the past.

Mr. ROGERS. I think that would be helpful.

(The following information was received for the record:)

HEALTH SERVICES RESEARCH

The past two decades have witnessed profound changes in the practice of medicine as well as in the organization and delivery of health care in this country. No institution has been more deeply affected by these changes than the general hospital. The expanded role of the hospital in community health and preventive medicine, as well as its role as a base for numerous new health programs, has made it a focal point for health care. The emphasis on these programs, together with the continually increasing expectation which the community evidences toward the hospital, have created a situation in which the hospital is rapidly becoming a true community health center.

The changing role of the general hospital has not developed without problems. Rising costs, shortages of key health professionals, inefficiency, waste, and inadequate facilities continually plague the hospital and frustrate attempts to maximize the general hospital's potential. The seriousness of these problems has been recognized and efforts have been made to find solutions.

The PHS Hospital System provides patient care to legally designated beneficiaries, conducts training for a wide range of health personnel from residents to nurses aides, operates individual and cooperative research projects, and participates in community programs. In brief, it mirrors the situation in the hospital health care field in this country, while differing from the norm, in that it is a centrally managed operation with full time salaried medical and dental staff.

Health Services Research in the hospitals of the Public Health Service is based on the recognition of both the current problems in the organization and delivery of health services and the use of Public Health Service Hospitals as a manageable, controllable environment to find solutions to these problems.

The Health Services Research group at the Baltimore Public Health Service Hospital has been actively engaged in carrying out this prescribed mission. A highly organized team consisting of many diversified specialties concentrate their knowledge on methods of increasing efficiency and quality in the delivery of health services. The current areas of investigation by the multi-disciplinary group emphasizes the application of modern technology to the Health Services System. One of the Health Services Research activities undertaken recently was planning, designing, and implementing an Automated Multiphasic Health Testing Center at the Baltimore PHS Hospital. This Center, called the Health Evaluation Center, was opened on March 10, 1970.

LIST OF PROJECTS, BALTIMORE PHS HOSPITAL

I. OPERATIONAL EXPERIMENTATION AND EVALUATION STUDIES

A. Completed

1. Evaluation of Government Furnished Uniforms in Lieu of Uniform Allowance.
2. The Implications of Changing From Reusable to Disposable Supplies in the Baltimore USPHS Hospital.
3. The Cost Per Injection of Using Disposable Syringes and Needles Versus Reusables in the Baltimore USPHS Hospital.
4. National Cancer Institute Drug Cost Study.
5. Outpatient Clinic Review Study.
6. Evaluation of a Tape-Edited Typing System in a Medical Record Transcription Unit.
7. General Outpatient Clinic Flow Study Designed to Describe and Optimize Patient Flow.

B. Current

1. Drug Distribution System Study.
2. Comparison of Outpatient Study Results.
3. Centralized Appointment System.

4. Development and Use of Clinical Associates (Physicians' Assistants) with University of Kentucky.
5. Development of a Health Index.

II. MEDICAL DIAGNOSIS

A. Completed

1. Computer Programs to aid in the Determination of Left Ventricular Volume and Cardiac Flow.
2. Study on Curve Fitting of Laboratory Values.

B. Current

1. Laboratory Values of Medically Normal People.
2. Automated Method for Measuring Conduction Time in Human Peripheral Nerve Conduction Velocity Studies.

III. ARCHITECTURE/PLANNING STUDIES

A. Completed

1. Exploratory Design of Health Facilities with Rensselaer Polytechnic Institute students.
2. Design of Outpatient Clinic, Emergency Room, and Health Evaluation Center Facilities for USPHS Hospital, Baltimore, Maryland.
3. Environmental Health System, Doylestown, Pa.
4. The Study of Mobile and Relocatable Health Screening Facilities with Texas A&M University.

B. Current

1. Planning Community-Organized Schools and Health Facilities for the Mantua Area of Philadelphia, with Students of the Pennsylvania State University.
2. Planning Urban Health Centers with Princeton University.
3. Planning of Community Mental Health Centers with Students of the Syracuse University.

IV. COMPUTER APPLICATION STUDIES

A. Completed

1. BLDGAS: Data for four time periods are processed, oxygen content of plasma and cells are predicted from pO_2 saturation, temperature and hemoglobin concentration.
2. ALLCLR: Computes renal excretion parameters of up to 16 substances.
3. INOSM: Calculates body surface, urine flow rate and osmolal clearance parameters.
4. CER: Calculates serum ceruloplasmin for the sample and blank determined by spectrophotometer.
5. PLATE: Calculates total platelet dose per unit of blood, 1 hour, 12 hour, and 36 hour post transfusion increments.
6. CROOK: Calculates protein fractions present in serum.
7. HEMAT: Tabulates hematologic data using body surfact and four time periods, blood pressure, heart rate, etc.
8. DEBES2: Compiles cost data and analysis by department on inpatient, outpatient, internal, and external nonhospital, cost per patient day and departmental unit costs.
9. FORMUL: The "Runoff" function developed by Dr. Liebman, The Johns Hopkins University, was used as a device to create and update a drug list.
10. RESCH: Developed by M. Resch, The Johns Hopkins Hospital, schedules elective surgical patients subject to the constraints of available capacities of four hours in surgical suites and of 20 beds in a hospital.
11. ASTHM: Developed by Dr. Charles Flagle, The Johns Hopkins University, is an asthma screening program.
12. ASTWEL: Demonstration program, question-answer participation.
13. TRICRB: Calculates disintegration per minute from Tricard counter.
14. OSLER: Nurse staffing requirements by patient classification.
15. MNCV: Rodger Nelson, Physical Therapy computes motor nerve conduction velocity for human peripheral nerve.
16. SED: Cell and Rotor Statistics. Computes the diameter, interface radius, rotor rpm and density.

17. Position Control: Written by Mrs. Juanita Anderson to supply management information on the number of positions filled and unfilled and certain characteristics of those positions.
18. A Program to catalogue Computer Programs on the 360/40 at the Johns Hopkins School of Hygiene and Public Health for Health Services Research, Baltimore.
19. A Program for input of Data from the Interim Health Evaluation Center and for output in a specified format.
20. A Program to plot in histogram form data on hospital admissions.
21. A Program to list all drugs in the hospital formulary with capability of updating the list.
22. A Program to implement reporting of bacteriology laboratory data.
23. A Program to provide a summary of bacteriological drug resistance.

B. Current

1. The use of the Time-Sharing Computer.
2. The development of list processing programs for general information retrieval.
3. The development of software for the IBM 1050 terminal to The Johns Hopkins School of Hygiene IBM 360/40 computer.
4. A program to provide a summary of weekly and cumulative data on drugs for the National Cancer Institute Research Program.
5. A program to score by computer the MMPI Psychological tests.
6. The implementation of GPSS/360 at The Johns Hopkins School of Hygiene.
7. Design of the software for the System uses of the CDC 915 OCR AND CDC 1700 at the Baltimore USPHS Hospital.
8. A BASIC language simulation program for analysis of the patient flow in the Health Evaluation Center.
9. A GPSS Simulation Program for analysis of patient flow in HEC.

V. HEALTH EVALUATION CENTER PROJECTS

A. Completed

1. The design of Health Evaluation Center Test Stations.
2. The selection of medical equipment for the H.E.C.
3. The design of the Data Processing System for the Health Evaluation Center.
4. The selection of Data Processing equipment.
5. Task analysis for HEC personnel.
6. The development of job descriptions for HEC personnel.
7. The development of the procedure manual for the HEC.
8. The design of the interim HEC.
9. The design of the method for processing laboratory specimens for the HEC.
10. Physical examination input format.
11. HEC equipment matrix.

B. Current

1. Development of MHS annotated bibliography.
2. Modification of the MMPI psychological questionnaire for the HEC.
3. Development of the HEC unit of consumption.
4. Design of the HEC drug consultation.
5. HEC medical equipment testing procedures.
6. HEC report to the physician.
7. Medical history questionnaire.
8. Body system test matrix.
9. HEC patient follow-up procedures.

Dr. HINMAN. We also have a computer center in which we are evaluating data processing and data handling in support of our hospital activities.

A second major research area is one that you have heard about a great deal, and that is the Baltimore Cancer Research Center, which is a collaborative project with the National Cancer Institute administered by the two agencies, the Health Services and the Mental Health Administration and the National Institute of Health, to provide 35 beds and supporting laboratory and patients care services to treat pa-

tients with specific types of cancers. This is an investigative program. Patients come from all over the country, although the majority of them come from within a 100-mile radius of the city.

This program is staffed by professionals, both from our organization and from the National Institutes of Health, and has a very unique relationship that has been productive, I think, for both the hospital and the National Institutes of Health.

The third major area of research is one in cardiovascular diseases. We have a major laboratory for performing cardiac function studies. As a matter of fact, there is only one other institution in the city that can do the full range of services we can. There are three major laboratories in this city, two universities, and our hospital, and as I say, only one other can do some of the studies that we do. These studies are available not only to our beneficiaries but to referrals from community physicians. We have become a major referral center for physicians in our immediate area because the waiting list at the two universities is so long that they could not get certain studies done on patients on an expeditious basis.

Other studies and programs of this unit include a heart disease detection program at the Social Security Administration in which we have screened the Federal employees there. This is an affiliated program approved by management and by the employees' union there, and strongly supported by the union and the Social Security Administration. If abnormalities are detected in this screening program the patients are referred to their own private physicians for evaluation and treatment, or if they do not have one, or wish us to do it, we will perform the evaluation.

We are doing studies in hypertension, looking at the question of whether moderate hypertension should or should not be treated. That simple question is not yet answered. And our hospital is participating on a cooperative basis—seven of the Public Health Service hospitals are involved in this study. It is supported by a National Heart and Lung Institute grant.

Another program is a lipid intervention project. This is a prototype study sponsored by funds from the National Heart and Lung Institute utilizing personnel from the Social Security Administration, NIH, and our hospital in a cooperative endeavor to identify young adults with abnormalities of their lipo-proteins, and put them on various therapeutic regimes to see if this would make any difference in the long-term incidence of disease. We feel that this may be a very important program, and if it looks as if our prototype works, it is intended to be expanded by the NIH to other institutions.

A third major study is a national effort on coronary artery disease. There are 55 clinics: university clinics, community hospitals, and Public Health Service hospitals, throughout the country participating in this study to take middle-aged men who had a heart attack, and put them on a cholesterol lowering drug or a placebo to see if this would make any difference in the recurrence of the disease.

There are other research programs going on in the hospital. And I will be glad to furnish a little bit more identification of them for the record.

Mr. ROGERS. That would be fine.

(The following information was received for the record:)

On-Going or Recent Research

CLINICAL INVESTIGATIONS

Project title:	*Investigators*
"The Development of Catheter Tip Transducers for the Measurement of Instantaneous Blood Velocity and Flow."	Dr. J. Richard Warbasse; Dr. Ronald Gilillan; Dr. Henry Babitt; Dr. Karl Hammermeister.
"Instantaneous Cardiac Ontput Measurements by Impedance Plethysmography and Pressure Gradient Methods."	Dr. Roy Steigbigel; Dr. Henry Babitt; Dr. Barry Hellman; Dr. Ronald Gilillan; Dr. J. Richard Warbasse.
"Measurement of the Immediate Effect of Cardioangiography on Left Ventricular Function."	Dr. Karl Hammermeister; Dr. Ronald Gilillan; Dr. Henry Babitt; Dr. J. Richard Warbasse.
"Measurement of the Effects of Positive Inotropic Agents on the Intact Heart and on Isolated Heart Muscle: Force-Velocity-Length Relationships and Myocardial Oxygen Consumption."	Dr. Robert Boerth; Dr. J. Richard Warbasse.
"Left Ventricular Mechanics: Instantaneous Force-Velocity Relations In Man."	Dr. Henry Babitt; Dr. Karl Hammermeister; Dr. J. Richard Warbasse.
"Study of Relationship Between Biochemical Changes and Hemodynamic Events in Patients with Coronary Artery Disease."	Dr. Karl Hammermeister; Dr. Ronald Gilillan; Dr. Henry Babitt; Dr. J. Richard Warbasse.
"Evaluation of the Clinical Validity of the Electromagnetic Tape Recorded Electrocardiogram and of the Radiotelemetered Electrocardiogram."	Dr. Ronald Gilillan; Dr. Roy Steigbigel; Dr. Barry Hellman; Dr. J. Richard Warbasse.
"An Evaluation of the Antiarrhythmic Effect of Bretylinm Tosylate in Acnte Myocardial Infarction."	Dr. Henry Babitt; Dr. J. Richard Warbasse.
"Validation of Left Ventricular Biplane Angiographic Volnmes and Single Plane Cineangiographic Volumes."	Dr. Karl Hammermeister; Dr. Henry Babitt; Dr. Ronald Gilillan; Dr. J. Richard Warbasse.
"Controlled Study of the Value of Prophylactic Use of Intravenous Lidocaine in Treating Patients With Myocardial Infarction."	Dr. Roy Steigbigel; Dr. J. Richard Warbasse.
"Evaluation of the Effects of Antihistamines on Baroreceptor Reflex Vasodilatation."	Dr. Robert Boerth.
"Electrocardiographic Evaluation of Post-Myocardial Infarction Patients and Angina Pectoris Patients dnring Sexual Intercourse."	Dr. Melvyn Greberman; Dr. Ronald Gilillan; Dr. Henry Babitt; Dr. Roy Steigbigel; Dr. J. Richard Warbasse.
"Cooperative Study of Drugs and Coronary Heart Disease."	Dr. Ronald Gilillan; Dr. Henry Babitt; Dr. Karl Hammermeister; Dr. J. Richard Warbasse.
"Cooperative Study of Hypertension."	Dr. Roy Steigbigel; Dr. Robert DeBusk; Dr. J. Richard Warbasse.

DENTAL DEPARTMENT

Project title:	*Investigators*
"Reliability of Panorex Interpretations of Maxillary Sinus Pathosis."	Dr. Horace E. Lyon; Dr. Glen Elliott; Dr. Bernard Marsh; Dr. George Murphy.

Project Title:	*Investigators*
"Design and Development of the Multiphasic Health Screening Clinic."	Dr. Richard K. C. Hsieh.

(a) The design of the Health Evaluation Center test stations.

(b) The selection of medical equipment for the Health Evaluation Center.

(c) The design of the data processing system for the Health Evaluation Center.

(d) The selection of data processing equipment.

(e) Task analysis for Health Evaluation Center personnel.

(f) The development of job descriptions for Health Evaluation Center personnel.

(g) The development of the Procedure Manual for the Health Evaluation Center.

(h) Design of the Interim Health Evaluation Center.

(i) Design of the method for processing laboratory specimens for the Health Evaluation Center.

(j) Physical examination input format.

(k) Health Evaluation Center equipment matrix.

(l) Development of a Multiphasic Health Screening annotated bibliography.

(m) Modification of the MMPI psychological questionnaire.

(n) Development of the Health Evaluation Center Unit of Consumption.

(o) The design of the Health Evaluation Center drug consultation.

(p) Health Evaluation Center medical equipment testing procedures.

(q) Health Evaluation Center report to the physicians.

(r) Medical history questionnaire.

(s) Body system testing matrix.

(t) Health Evaluation Center follow-up procedures.

(u) Computer evaluation of electrocardiograms.

(v) Laboratory values of medically normal people.

(w) The development of list processing programs for general information retrieval.

(x) A program to score and interpret the MMPI by computer.

(y) The implementation of GPSS/360 at The Johns Hopkins School of Hygiene.

(z) The design of software for the system uses of the CDC 915 OCR and CDC 1700 at the Baltimore PHS Hospital.

(aa) A BASIC language simulation program for analysis of the patient flow in the Health Evaluation Center.
(bb) A GPSS simulation program for analysis of patient flow in the Health Evaluation Center.

OPHTHALMOLOGY DEPARTMENT

Project title:	*Investigators*
"Mechanisms of Expulsive Choroidal Hemorrhage"	Dr. William E. Newby.
"Pars Plana Cysts in Multiple Myeloma"	Dr. Peter P. Gudas, Jr.

PATHOLOGY DEPARTMENT

Project title:	*Investigators*
"Renal Biopsy in Patients with Hodgkins Disease Undergoing Laprotomies for Staging."	Dr. John C. Sutherland; Dr. Harold E. Ramsey; Dr. Michael R. Mardiney.
"Diagnostic Laparotomy & Splenectomy for Staging Hodgkin's Disease."	Dr. Stanley Lowenbraun; Dr. Harold E. Ramsey; Dr. John C. Sutherland; Dr. Arthur A. Serpick.
"Regional Lymphadenopathy of Lymphoma-Leukemia. An Autopsy Study."	Dr. Frederick W. Bauer; Dr. Vija L. Aisters-Bauer.
"A Retrospective Histochemical Study of Lung Tumors."	Dr. Frederick W. Bauer.
'Hypocalcemic Heart Disease."	Dr. Frederick W. Bauer.
"Computerization of Autopsy Data."	Dr. Lawrence Yamamoto; Dr. Frederick W. Bauer.

PHARMACY DEPARTMENT

Project title:	*Investigators*
"The Clinical Efficacy of the Self-Sterilizing Agents Used in Selected Ophthalmic Solutions Prepared at the USPHS Hospital, Baltimore, Md."	Christopher Konrad.
"Automatic Ward Stock Replenishment and Inventory Control Using Automatic Data Processing-Study on Adaptability and Effectiveness."	Lamar Orr.
"Cost Comparison Between Nurse vs. Pharmacist Responsibility for Intravenous Additives."	William Zelimer.
"The Distribution of Daunomycin in Mice."	Leon Moore.
"Predicting Manpower Needs for an Outpatient Pharmacy."	Paul J. LeSage.
"Cost Analysis of Single-Unit Packaged Drugs vs. Multiple Unit Packaging."	Samuel Henley.
"The Feasibility and Evaluation of a Decentralized Unit-dose Drug Distribution System on a Single Ward of a Government Hospital."	Larry Swanson; Richard Taffet.

PHYSICAL THERAPY

Project title:	*Investigators*
"Motor Conduction Velocity of the Auxiliary Nerve."	Dean P. Currier.
"Use of a Recruitment Index for Assessing the Functional Integrity of Motor Nerves."	Dean P. Currier.
"The Effect of Early Mobilization Exercises Compared to Immobilization of Postoperative Medical Meniscectomies."	Roger M. Nelson.

RADIOLOGY DEPARTMENT

Project title:	*Investigators*
"Review of Radiographic Findings of 250 Leukemic Patients."	Protocol not completed as yet.

SURGICAL DEPARTMENT

Project title:	*Investigators*
"Influence of Sublethal Infection on the Growth of Fibrosarcoma in Rats."	Dr. Harold E. Ramsey; Dr. John C. Sutherland; Dr. Jordon Holtzman.
"The Effect of Disease and Drugs on the Activity of the Hepatic Microsonlal Mixed Function Oxidase."	Dr. Harold E. Ramsey; Dr. John C. Sutherland; Dr. Jordan Holtzman.
"Diagnostic Laparotomy in Hodgkin's Disease Patients."	Dr. Harold E. Ramsey; Dr. Arthur Serpick; Dr. Stanley Lowenbraun; Dr. John Sutherland.

PITTSBURGH OUTPATIENT CLINIC

Project title:	*Investigators*
"Study of Family with Oculopharyngeal Muscular Dystrophy."	Dr. Kenneth M. Master.

BALTIMORE CANCER RESEARCH CENTER

Project title:	*Investigators*
"Effects of DEAE-Dextran on L-1210 *in vitro*."	Dr. Jerome B. Block; Dr. J. J. Oppenheim.
"Feasibility Study for Contract Research Microbiology."	Dr. Viola Young; Dr. Gerald Vermuelen.
"Environmental Control of Pathogenic Bacteria."	Miss D. Kenton; Dr. Viola Young.
"Detection and Control of Pseudomonas."	Mrs. Marcia Moody; Dr. Viola Young; Dr. Gerald Vermuelen; Mrs. Delores Kenton.
"Study of Infection Risk of Scalp vein needles."	Dr. Stanley Lowenbraun; Dr. Viola Young; Mrs. Delores Kenton.
"Broad Spectrum Bacterial Antibody Evaluation in Cancer Patient Sera."	Mrs. Marcia Moody; Dr. Viola Young.
"Computerized Program for Reporting Results of Clinical and Research Microbiology by a Laboratory Geographically Removed from the Patient Care Area."	Dr. Gerald Vermuelen; Dr. Viola Young; Dr. Richard K. C. Hsieh; Dr. Stephen Schwab.
"Clinical Significance of Serum and Urinary Muramidase Activity in Leukemia."	Dr. Peter Wiernik; Dr. Arthur Serpick.
"Platelet Transfusion Therapy"---	Dr. Arthur Serpick; Dr. Walter Miller.
"Clinical Trails of Chemotherapeutic Agents in Patients with Cancer."	Dr. Arthur Serpick.

"Computer Applications in Blood Component Therapy."	Dr. Walter Miller; Dr. Yamamoto; Dr. Serpick; Dr. Hirsch.
"Automated Data Retrieval System for Experimental Chemotherapy Studies."	Dr. Winston Satterlee; Mr. Stephen Schwab; B. Murray; Mr. J. Myers.
"A Survey of Transfusion Associated Hepatitis and Its Possible Modification by Gamma Globulin."	Dr. Walter Miller; Dr. A. Serpick.
"A study of 6-Mercaptopurine Metabolism in Cancer Patients."	Dr. Jerome Block; Dr. A. Serpick.
"A Study of Lapachol Disposition in Man."	Dr. Jerome Block; Dr. Arthur Serpick; Dr. P. Nyak.
"Drug Distribution in Patients and in Human Tumors."	Dr. Michael Walker.
"Intrathecal Toxicity of Chemotherapeutic Agents in Monkeys."	Dr. Michael Walker.
"Evaluation of Pharmacodynamics of Regional Perfusion."	Dr. Michael Walker; Dr. Gaylan Rockswald; Dr. Steven Goldware.
"Toxicology of Radiation and Chemotherapeutic Agents."	Dr. Kirkland Brace.
"Effect of Free Fatty Acids on Ion Transport."	Dr. K. Ahmed.
"Pharmacology of Daunomycin. Physical Chemical Properties and Metabolism."	Dr. Nicholas Bachur; Mr. James Cradock.
"Action of Drugs on Platelet Membranes."	Dr. J. Moake; Dr. K. Ahmed; Dr. N. Bachur.
"Pharmacology of Daunomycin. Tissue Distribution and Excretion."	Dr. N. Bachur, Mr. J. Cradock.
"Mechanism of Hydroxylation of Foreign Compounds.	Dr. J. L. Holtzman; Dr. T. Gram.
"Distribution and Excretion of Daunomycin in Man."	Dr. D. Alberts; Dr. N. Bachur; Dr. J. Holtzman.
"Development of Specific RNA ases."	Dr. C. Levy.
"Isolation of Homogeneous Populations of Nucleated Cells from the Peripheral Blood."	Dr. M. Mardiney; Dr. R. Mangl; Dr. M. Abeloff.
"Development of a Transplantable Tumor for Study of Chemotherapy Induced Remissions."	Mr. Stewart Humphreys; Dr. Michael Mardiney.

Dr. HINMAN. There is another area of service that the hospital is engaged in. And this is our community service. We support the endeavors of a number of health agencies in the city of Baltimore, both voluntary health agencies, the municipal, State, and Federal health agencies. We do this by volunteers, and we do this on reciprocal agreement. There are a number of different ways in which we perform these services. But our staff has become intimately involved in the health care community in the city of Baltimore.

I have a little bit more amplified list of this which I will furnish for the record to save your time.

Mr. ROGERS. Thank you.

(The following information was received for the record:)

COMMUNITY INVOLVEMENT

The Baltimore Public Health Service Hospital has, by tradition and by statute, been an institution dedicated to providing care for well circumscribed groups of beneficiaries. The hospital and the Public Health Service in general have fulfilled the needs of these groups admirably. It has been apparent to both the ad-

ministration and many of the individual staff members that there is an incongruity in a relatively well-equipped, relatively well-staffed hospital existing either within or in direct contact with communities whose medical needs have not been met by existing private health delivery systems. The concern with this incongruity has been growing and over the past several years individual departments within the hospital have developed programs to help cope with some of the unmet acute medical needs of the Baltimore metropolitan community. These programs have been limited when compared with the tremendous needs of certain population segments within our community. It was necessary to develop these programs through existing mechanisms such as special study status and more recently by the designation of patients in the "Cooperative Community Program" category. It has been the feeling of both the administration and staff that these attempts at supplying more needed medical support to the community were inadequate but were all that could be accomplished under the existing structure and the existing goals of the United States Public Health Service.

There have been other reasons for the interest in developing a broader beneficiary base for the hospital. It has been apparent that certain types of patients were not generally available in the populations we serve and they are necessary for the development of meaningful training programs as well as the development of meaningful research projects. A broadened beneficiary base has been desired due to the general decrease in numbers of American Seamen who are presently seeking care in federal facilities.

At the present time there are several community programs functioning within the hospital under the direction of individual departments. In addition to these programs, the administrative office, and specifically the Director, has made multiple contacts with community leaders and community organizations to lay the very necessary groundwork for eventual community participation. The programs presently in operation within the hospital are of two types: (A) Those programs designed for the delivery of health care to persons in the community, and (B) those programs designed to supply training to persons in the community for health care activities. A brief outline of these programs follows:

A. Those programs designed for delivering health care to persons in the community

1. A large number of the senior physicians stationed at the Baltimore Public Health Service Hospital have been appointed to the University Departments pertinent to their specialties. Originally these appointments were not made because of their relevance to community involvement, however, they serve as a valuable means for liaison with community institutions and a network for communications regarding health care delivery in the community.

2. The Baltimore Cancer Research Center acts as a referral facility for patients with certain types of hematologic and solid malignancies and accepts large numbers of non-federal beneficiaries referred from the community. The staff has been actively developing a cooperative oncology unit in two community hospitals for the purpose of lending their expertise in oncology to the community hospitals and improving facilities available for patients with malignancies. Over 95% of the patients treated are community referrals with approximately 40% coming from Maryland.

3. The Cardiology Department has developed and is operating a referral service for community physicians to supply specialized cardiac procedures that are not readily available in the community. In 1969 approximately 40 such patients were referred from private physicians. The Cardiology staff is actively involved in the operation of certain coronary care units in community hospitals. In addition, the Cardiology Department has developed a large Heart Disease Screening Program with the Social Security Administration for the purpose of identifying parameters which may indicate a pre-disposition for cardiac disease. This program involves approximately 16,000 employees of the Social Security Administration and will be a continuing project for several years. Recently sophisticated lipo-protein studies have been added to the screening.

4. In conjunction with The Johns Hopkins Hospital, Union Memorial Hospital, University of Maryland Hospital, Church Home and Hospital, and the Western Health Clinic of the Baltimore City Department of Health, the Department of Internal Medicine has developed a referral service for patients needing hospitalization with acute problems for whom hospitalization is not available in the referring institution. This has become a valuable source of acutely ill patients for this hospital as well as a much appreciated service to other institutions and the community.

5. The Ophthalmology Department has been quite active in both the development and administration of the Medical Eye Bank of Maryland and in addition has supplied to the Maryland State Department of Health an Ophthalmologist to staff an Eye Clinic in Chestertown, Maryland, for the care of indigent patients. This program has made available an Ophthalmologist to a population who previously had no such care available.

6. The Department of Pediatrics has cooperated with the Baltimore City Department of Health to help alleviate the tremendous shortage of school physicians available in City Schools. A Pediatrician presently visits City Schools three afternoons weekly to hold clinics for evaluation of current problems and screening of referred children. Each member of the Department of Pediatrics participates in this program and all agree with the City School System that it is a worthwhile project. In addition, the Department of Pediatrics performed physical examinations on approximately 150 children from deprived neighborhoods who took part in the NCAA summer sports program at The Johns Hopkins University in 1969.

7. The Pathology Department participates in the screening program for health evaluation of physicians attending the annual Medical and Chirurgical Faculty Meetings.

8. Three staff members serve on Maryland Regional Medical Program Committees. Numerous staff members belong to voluntary health agencies (Dr. Hinman is president of the Kidney Foundation of Maryland).

9. Dr. Hinman is President of the Greater Homewood Community Corporation and is a member of the East Baltimore Advisory Commission of the Community Action Agency.

B. Those programs designed to supply training in health care activities to persons in the community.

1. The hospital is actively involved in PROJECT GO which supplies information to seventh and eighth grades in the City Schools about health related professions to assist in their career selections. This entails a considerable amount of time for many individual staff members.

2. The hospital participates in the Neighborhood Youth Corps Program by supplying on-the-job training on a part-time basis to disadvantaged youths to assist in learning skills for future employment.

3. The hospital supplies work opportunities to the In-School Neighborhood Youth Corps Program employing 10–12 students each summer in varied work categories.

4. The Maryland State Employment Department, in conjunction with the hospital, offers summer opportunities for high school age students to work in all areas of the Hospital.

5. An active MDTA education program for disadvantaged youth in conjunction with the Baltimore City Public Schools, Division of Adult Education, offers three months of nurses aide training at the Hospital to make it possible for enrollees to be certified and employed as nurses aides. These enrollees are primarily from the center city area.

6. The Office of Financial Aid of The Johns Hopkins University and the Hospital supply part-time work to 15 students through the College Work-Study Program who could otherwise not easily afford to attend college.

7. The Department of Dentistry is actively involved in the training of dental assistants and on an annual basis courses and conferences for the training of dental assistants throughout the state are given.

8. The School for Medical Record Librarians has offered regular consultation to other hospitals in the community to improve their record departments. They provided the technical consultation to Provident Hospital when it was setting up the Provident Neighborhood Health Center.

9. The Occupational Therapy Department assists in training O. T. Aides from Baltimore Community College.

10. The Social Service Department is participating in a Community Alcoholism Trainee Program.

11. In January 1971 a "mini-mester" program was begun with Loyola College and 5 students are spending 4 weeks full time at the Hospital.

Dr. HINMAN. I have quickly gone through a number of our program activities. I would be glad to answer any questions you might have about specific programs.

Mr. ROGERS. What is the area—do you know the number of people, say, in Baltimore who really are without medical care? I understand it was quite a large number.

Dr. HINMAN. Yes, sir. I believe I saw in the press that the city health department had said that there are five census tracts in the city of Baltimore that have no physicians at all. With other members of the staff, I have been in discussion with a group known as the Homestead Montebello Community, which has somewhere between 24,000 and 30,000 residents, is located approximately 1 mile east of the hospital in the city, and constitutes a changed or still changing neighborhood. It was essentially an all-white neighborhood and it is becoming a predominantly black neighborhood. As the conversion has occurred, physicians, dentists, and pharmacists have moved out of the neighborhood. And until this past month there were no physicians, no dentists, no pharmacists providing service to the neighborhood. Recently an obstetrician has moved into the neighborhood and is performing some part-time services to the neighborhood.

This is not a ghetto in the classic sense. The average income in the area, I believe, is close to $8,800. There are people who are eligible for title 19, title 18, and they have Blue Cross coverage or other means of payment, but they have no health care services.

Mr. ROGERS. They just cannot get them?

Dr. HINMAN. No, sir. They have to use emergency rooms in hospitals adjoining their community.

In the northern sector of the city, in the segment that we call the north central wedge, there are 155,000 residents. There are three hospitals, if you include our hospital, which could provide backup services to the residents of these areas.

Mr. ROGERS. Doctor, that gives us, I think, a very comprehensive picture of what you are doing, and it sounds like a most active and comprehensive program, and a very effective one. We appreciate your being here and giving us the benefit of this background.

Dr. HINMAN. Thank you very much, sir. And I will send the missing parts of my comments.

Mr. ROGERS. Thank you.

This will conclude the hearings for today. And the committee will stand adjourned subject to the call of the Chair.

It is the intention of the committee to travel to New York tomorrow to look at the Staten Island Hospital. And then I am very hopeful that we can invite and have present the Secretary of HEW to answer some very pertinent questions after we have gone into all of these facts now.

The committee stands adjourned.

Thank you very much.

(Whereupon, at 12:55 p.m. the subcommittee adjourned, to reconvene subject to the call of the Chair.)

OPERATION OF PUBLIC HEALTH SERVICE HOSPITALS

FRIDAY, MARCH 12, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND PUBLIC WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Staten Island, N.Y.

The subcommittee met at 9:30 a.m., pursuant to notice, at the U.S. Public Health Hospital, Staten Island, N.Y., Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The Subcommittee on Public Health and Welfare of the Interstate and Foreign Commerce Committee of the House of Representatives will come to order.

We are holding an official hearing this morning here at the hospital to try to obtain more facts in the proposed closing of public health hospitals and clinics as set forth in the President's budget which has requested no funds.

We have been holding hearings in Washington and I might state that the witnesses from the Department of Health, Education, and Welfare have stated that they are now modifying their position; that they do not intend just to come out and close hospitals. But we have yet to receive from them official request for the budget figures. And we are going to try to press the Secretary to get this before the Congress as quickly as possible.

It is a pleasure for the committee to be in the district of our good friend and colleague who is on the full committee of Interstate and Foreign Commerce, Hon. Jack Murphy. He has been a leader in the fight to prevent these closings and I know the people in this area are grateful to him and to the committee for the great work he has done in bringing to the attention of the Congress and the American people this problem.

Before we begin hearing witnesses, I want to say this on behalf of the committee, that I read in the New York Times today that the director of the hospital has received a call from an official of the Department of HEW warning them that anyone who testified before this committee would be doing so at his own risk. Whether that's true or not, I don't know, but we intend to find out. And I want to assure anyone who testifies that you will have the full protection of this committee in any testimony you may give, and we hope to get to the truth.

We have already passed a law which is on the books that anyone who intimidates a witness before the Congress of the United States has committed a criminal act and shall be subject to criminal penalties. We will see that that law is enforced. If there is any indication of intimidation I hope you will come forward and let this committee know and we will see that official action is taken by the Department of Justice or else through the contempt of Congress itself.

Without objection I would like to insert the New York Times' article into the record at this point.

[From the New York Times, Mar. 12, 1971]

HOSPITAL STAFF WARNED OF 'RISK' IN TESTIFYING BEFORE COMMITTEE

The chief administrator of the United States Public Health Service Hospital on Staten Island warned his professional staff yesterday that there would be an "element of risk" for any member who expressed views contrary to the policy of the Department of Health, Education and Welfare at a Congressional hearing at the hospital today.

The administrator, Dr. Nicholas Galluzzi, confirmed this last night after four doctors assigned to the hospital called The New York Times and charged that an effort had been made to "muzzle" the staff for the hearing. The doctors declined to identify themselves, saying they feared "reprisals."

The hearing by the health subcommittee of the House Interstate and Foreign Commerce Committee is part of the effort to determine whether to close eight hospitals operated by the Public Health Service. The closings have been proposed by the Department of Health, Education and Welfare, which controls the Public Health Service.

Dr. Galluzzi said the instructions, given at a staff meeting yesterday, had originated in Washington. He said that he had merely been "advising them of a message I had received from my headquarters."

"This is a complex situation dealing with HEW policy and the staff here is not in a position to discuss it," Dr. Galluzzi said. "I advised them they could present any facts, figures or data, but since they're not in a position to discuss departmental policy they should not do so."

The doctors who called The Times charged that the instructions amounted to "rigging" a Congressional hearing. They said that, as uniformed members of the Public Health Service, they were subject to arbitrary transfer and, in the case of some internes and residents, activation for Coast Guard duty.

The hospital is at Vanderbilt Avenue and Bay Street, in the Clifton section.

Mr. ROGERS. We are pleased to have with us the distinguished members of the subcommittee who have taken a most active interest in this matter, Congressman Peter Kyros from the State of Maine; Congressman James Symington from the State of Missouri; Congressman William Roy of the State of Kansas. We have with us also our staff man who contributes greatly to the work of this committee, Mr. James Menger.

With those few words, Mr. Murphy, I think we will let you arrange the agenda, if you will, and present witnesses that you think the committee should hear.

Mr. MURPHY. Thank you, Mr. Chairman.

Here at the outset I would like to congratulate you and my colleagues on the Committee on Public Health and Welfare for your extra effort in coming many hundreds of miles early in the morning, to see firsthand what type of facility is here at Clifton, on Staten Island. I know that the other areas of the country are going to receive just as careful consideration and attention from the committee.

I would like to point out to the Staten Islanders that Congressman Symington's great great grandfather was General Wadsworth, and our own Fort Wadsworth was named after him. He made a point of that at the last committee hearing.

Congressman, we certainly welcome you back to one of the sites of the Symington family beginnings.

This committee on Public Health undertook these hearings and has spent many days and nights in Washington hearing witnesses from all over the United States.

A Senate committee with comparable jurisdiction under the chairmanship of Senator Edward Kennedy has also held similar hearings.

Congressman Rogers and I, and Congressman Kyros serve on another committee on Merchant Marine and Fisheries. In December and January we had long and arduous hearings on this very problem in Washington and the hearings here this morning will be a part of these official hearings.

Many of the men that will make preliminary statements this morning, such as the borough president and the borough development director, Mr. Holdmeyer, have been to Washington and have already testified at great length and have gone into much detail.

We have representatives here from virtually every organization that has a legal interest in this hospital—laymen, Government employees, Public Health Service employees—and they have already testified.

As a consequence, this morning we will hear testimony for several hours and, if people are asked to place their statements in the record, I ask that they understand and appreciate the fact that we have many who want to be heard.

There are other public officials; namely, Councilman Robert Lindsey, Councilman Edward Curi, and also Asemblyman Edward Aymen who indicated to me that they could not make the hearing this morning to present a statement. However, they have read my statement presented to the committee this week. They endorse that statement and asked that the record reflect that Councilman Lindsey and Councilman Curci have endorsed my statement and position. In brief summary I support the retention of the mission of the hospital here with an expansion of its facilities into the community health services of this community. Greater medical assistance is needed in this overburdened area, not just from the Federal Government, but from the State and local governments as well.

I would also like to point out that we have here, and the committee has already received the reports of the investigating teams that the Department of Health, Education, and Welfare sent throughout the country, the overall summary and individual hospital summary of the site visits of January 19 to 22. It is very comprehensive. I think it is also very fair in its recommendations and in its findings.

It found that the hospital on Staten Island provides medical care resources in the community, goes into the training of health personnel for the community, gives research assistance to the community, helps support the economy, and provides employment. It points out what the major deterimental effects on the communities of America and the provision of community services would be if this hospital and others like it were not retained in their present roles.

Staten Island, of course, did rank No. 1 in the health, education and welfare rating system. There are other hospitals who are close, but we found, and the Department itself found, this community is in greater need of medical service from this hospital in addition to its regular mission than any other.

With that, Congressman Rogers, I think we should hear from Dr. Galluzzi, the very capable director of this hospital, as the first witness.

Mr. ROGERS. Thank you.

Dr. Galluzzi, the committee will be pleased to hear your testimony I might say that Dr. Galluzzi has taken the subcommittee on a tour of the hospital. We have seen the facilities and the work that is going on here. And, Doctor, we have been very impressed with the mission that you are accomplishing here.

STATEMENT OF DR. NICHOLAS GALLUZZI, DIRECTOR, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. GALLUZZI. Thank you, sir.

Mr. Chairman and members of the committee, I am pleased to attend this hearing.

This hospital can be truly characterized as a medical center with a wide variety of programs. They can be described in terms of the well known triad—health care, education and training and research. They are interlocking and really inseparable, each stregthens the other. The provision of health care to our patients is the basis of this triad.

In addition to our statutory beneficiaries we accept referrals from community physicians of difficult or complex diagnostic or therapeutic cases on a special study basis. We have particular expertise in the cardiovascular and renal electrolyte field with the only diagnostic cardiovascular and renal electrolyte laboratory on Staten Island.

Further, we accept referrals of emergency patients for hospitalization when no bed is available at the community hospitals. Since the Island hospitals are usually filled to capacity, this is a frequent occurrence.

In the area of education and training, we conduct a broad range of programs. These include medical, dental, and dietary internship, residency training in all of the patients accepted for pediatrics on OBGYN. We have subspecialties, fellowships in kidney and cardiovascular disorders.

Recognizing the need for health manpower in the allied health or paramedical field, we are progressively expanding and implementing programs in this area. These include training programs for laboratory technology and laboratory technicians, radiology technicians, practical nurses, as well as programs such as the Marine Physicians Assistants School, and the medical transcriber school, a high school paramedical training program, and a new program for the training of orthopedic assistants which will begin in the fall of 1971.

Many of the students in these programs are recruited from disadvantaged and unemployed groups and the programs provide entry into a productive role in society. Some of the programs are conducted entirely intermurally while others are affiliated with educational institutions, including the Staten Island Community College and Richmond College of the City University of New York, and Wagner College.

Our education efforts include unique programs in health education for employees and patients as well as for community groups.

We also provide a series of courses in continuing medical education for practitioners from the community.

Our research efforts are in both basic physiologic study and clinical research. We have been particularly productive in cardiac research

with much contribution in the area of electrophysiology and the conduction system of the heart. This work has gained international recognition.

The renal program includes sophisticated studies in the correlation of kidney physiology and the renal ultrastructure, electrolyte study, and the recently developed renal micropuncture laboratory.

We are very proud of our staff and the programs which have been successful because of their dedicated efforts and their innovative, creative thinking.

Mr. Chairman, I shall be happy to enlarge upon any of the programs in greater detail if you wish.

Mr. ROGERS. Thank you, Doctor.

We have, of course, gone through the hospital with you, we have asked a great number of questions so that we have a good bit of information. I don't know that it's necessary to go over it with you at this point.

I might state we have asked you to furnish, and if you will for the record, the shortage of equipment and the period of time for which that equipment has been requested, shortage of personnel, and the length of time a request has been in for funding for that shortage, any expansion or modernization requests and when those requests were made. With this we can put into a proper perspective what is needed to bring this hospital to an optimum efficiency.

May I ask you this question: Do you feel under any threat of retaliation to provide this committee with any information to answer any questions?

Dr. GALLUZZI. None at all, sir.

Mr. ROGERS. Were you advised that you would be on your own, as has been stated, on your own, if you come before this committee to answer questions? Were you advised from your headquarters to that effect?

Dr. GALLUZZI. Sir, I was reminded of the standard policy and since I am not in a policymaking role, and since the entire matter of departmental policy is rather complex, that these questions concerning departmental policy should be referred to a higher headquarters.

Mr. ROGERS. Were you told not to answer if the committee questioned in this area?

Dr. GALLUZZI. I was advised, sir, that I could present complete data, facts, figures, and programs and to refer other matters to higher headquarters.

Mr. ROGERS. And who advised you to this effect?

Dr. GALLUZZI. The director of my immediate division.

Mr. ROGERS. Is that, as stated in the article, Dr. Butler?

Dr. GALLUZZI. Yes, that's Dr. Butler.

Mr. ROGERS. Dr. Jack Butler?

Dr. GALLUZZI. Yes, sir.

Mr. ROGERS. I don't know that the committee would expect you to answer policy questions, but if there is any question that cannot be answered because of the restriction placed upon you, I would like for you to make it very clear that you are not answering because of that restriction and we will take that up directly with the Secretary and perhaps with the Department of Justice.

Mr. Kyros?

Mr. Kyros. Doctor, one of the programs you talked about was the cardiovascular program in your hospital. Is that right?

Dr. Galluzzi. Yes.

Mr. Kyros. You also talked about cardiac research at this hospital being done. I think it is a great program and I think you did a very fine job of showing us the hospital. You told us all the facts.

There was a piece of equipment in the cardiac section that was broken and inoperable. What was that piece of equipment?

Dr. Galluzzi. This is the diagnostic cardiovascular X-ray equipment.

Mr. Kyros. What does that equipment do?

Dr. Galluzzi. This equipment is used during a diagnostic catherization study.

Mr. Kyros. What relationship does that piece of equipment have to the treatment of the kinds of heart problems of patients coming into the section of your hospital?

Dr. Galluzzi. This equipment, of course, is important in making an accurate diagnosis in patients with valvular heart disease or other forms of heart disease.

Mr. Kyros. Do you treat that kind of patient?

Dr. Galluzzi. We do treat patients with all forms of heart disease except for providing open-heart surgery. We do not have such a program.

Mr. Kyros. Is that equipment also important in making arteriograms?

Dr. Galluzzi. It would be important in making coronary arteriograms.

Mr. Kyros. Which are required prior to certain kinds of surgery?

Dr. Galluzzi. Yes, for very specific indications in coronary artery disease such studies are indicated.

Mr. Kyros. So it is a vital piece of equipment to your cardiovascular unit setup there?

Dr. Galluzzi. It is a vital piece of equipment but I might add that in terms of coronary artery disease patients, since we don't have heart surgery programs, that it is not vital to our overall program. However, it is vital to our diagnostic studies and our research studies.

Mr. Kyros. How long has the equipment been inoperable?

Dr. Galluzzi. Approximately a year.

Mr. Kyros. Doctor, I understand from the discussions that we had when you were showing us the physical plant prior to meeting your staff, that you have made requests one way or another to the department for funding to take care of the equipment?

Dr. Galluzzi. We have made requests to our immediate division, the Federal Health Program Service.

Mr. Kyros. The question is a question of money and other priorities for the hospital. Is that the problem?

Dr. Galluzzi. Yes; the problem is the availability of funds.

Mr. Kyros. The next thing I want to ask you about, Doctor, is Marine physicians assistants program. What is that program?

Dr Galluzzi. This is rather a unique program for training merchant seamen to serve aboard those merchant vessels which do not carry a physician. These men would provide for the medical help needs of merchant seamen.

Mr. KYROS. Sort of like a Navy corpsman's job in case something happens?

Dr. GALLUZZI. This is rather an intensive program of training. About 1,100 hours of training over a 9-month period of time. So that these individuals are highly trained and can be indeed characterized as physician assistants, even though there may not be a physician aboard the vessel. There is a radio communication network between the vessel and the hospitals so that these individuals, having developed skills and diagnosis, through history taking and physical examination, can provide accurate information to a physician and in that way get immediate advice and carry through on the treatment.

Mr. KYROS. To your knowledge, Doctor, is this program carried on in your hospital the only one in the United States, or does it occur throughout other Public Health Service hospitals?

Dr. GALLUZZI. This is the only Marine physicians assistants program.

Mr. KYROS. Generally, then, this is a place where we can train people to be aboard the merchant marine?

Dr. GALLUZZI. Yes, sir.

Mr. KYROS. What other duties do they have? Would they be engineers?

Dr. GALLUZZI. There are full time employed in that capacity in health care.

Mr. KYROS. I see my time is up.

I want to say, Doctor, that I, along with the members of the committee, appreciate the time you took out this morning, your cooperation in taking us through the hospital, and your explanations of what you have here, your assets and some of your problems.

Thank you, Mr. Chairman.

Mr. ROGERS. Congressman Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

I also, Doctor, would like to thank you for your graciousness in taking us through a rather quick trip around the hospital.

I am also curious as to what is meant by the term "policy" as distinct from fact and data. Perhaps you can help the committee by telling us what you think Dr. Butler meant when he reminded you, as you put it, of the rules concerning discussion of policy.

Dr. GALLUZZI. I think he was conveying to me the concept that since policy or position matters are rather complex and complicated, and since individuals who are not in a policymaking role did not have all of the available facts, that it's best that they not enter into that kind of a discussion.

Mr. SYMINGTON. Do you consider yourself such an individual who does not have all the available facts?

Dr. GALLUZZI. I don't believe that I have all of the available facts.

Mr. SYMINGTON. You lack all the available facts to discuss policy, but what policy is it that you lack all the available facts to discuss?

Dr. GALLUZZI. Well, I believe the reference is to policy or position on the Public Health hospital service system.

Mr. SYMINGTON. As applied to this particular hospital, would you feel there is someone that knows more than you do about whether it should be closed?

Dr. GALLUZZI. I think the issue is no longer whether any hospital should be closed. I understand from Dr. Egeberg's testimony that the hospitals will continue.

The matter of discussion now is where the management of that hospital will lie, and that this is being explored.

Mr. SYMINGTON. You feel that is an area which you are not equally competent to discuss based on your position here?

Dr. GALLUZZI. I would agree that I do not have all of the necessary facts and information to honestly and objectively address myself to that question.

Mr. SYMINGTON. How long have you been the director here?

Dr. GALLUZZI. Since 1967.

Mr. SYMINGTON. Would you feel that in that period of time you could have formed an opinion as to the value of continuing this particular installation in the fashion it is now being operated?

Dr. GALLUZZI. Yes; I believe so.

Mr. SYMINGTON. For you to give me that opinion wouldn't constitute policy, would it, because it is not for you to make policy. Therefore, I would like your opinion.

Dr. GALLUZZI. You're asking my opinion concerning—my individual opinion concerning——

Mr. SYMINGTON. Yes; I don't expect you to be reflecting——

Dr. GALLUZZI. The mode of operation of this facility?

Mr. SYMINGTON. Yes.

Dr. GALLUZZI. My own individual opinion is that I would like to see the hospital continue under the present system of control.

Mr. SYMINGTON. Are there any particular changes which in your opinion should be undertaken?

Dr. GALLUZZI. Of conrse, in any hospital there are needs. There is a limitation on available funds on the health dollar. And we do have needs in several areas.

Mr. SYMINGTON. What you are saying is you would like to see the efforts you are now making supported to a greater extent financially?

Dr. GALLUZZI. Yes.

Mr. ROGERS. Dr. Roy? I might say that Congressman Roy is an M.D. and also a lawyer, so he catches us on all sides.

Mr. ROY. Thank you, Mr. Chairman.

I want to thank Dr. Galluzzi for the courtesies he has extended to us.

I don't know whether I catch you on all sides or whether I catch it on all sides. [Laughter.] Maybe it's an open question.

You stated to Mr. Symington that there are things, of course, that you are unable to bo because of budgetary limitations.

Do you have any programs which you would like to phase out, or any programs you feel are not serving a particular vital or useful purpose?

Dr. GALLUZZI. No, there are no programs that I feel could be phased out.

Mr. ROY. I, of course, see things somewhat narrowly in the sense that I am an obstetrician and gynecologist. And I was looking—very superficially—at the program in obstetrics and gynecology.

Do you feel that this program serves a necessary purpose commensurate with the expense of running the program in obstetrics and gynecology?

Dr. GALLUZZI. Yes, I believe it does, particularly in the area of training. Since we run an extensive training program for rotating interns, I think it's very important to have an obstetrical-gynecological service in training these interns.

I also feel in a general hospital, medical-surgical hospital, that there should be a full range of service. I think they all interlock, go hand in hand, and are part of the overall fabric. And the loss of any one of these services, I believe, weakens every other program.

Mr. ROY. How many medical officers do you have as far as obstetrics and gynecology?

Mr. GALLUZZI. We have three trained individuals.

Mr. ROY. How many medical officers devote their full time to obstetrics and gynecology?

Dr. GALLUZZI. Three, plus interns that are assigned there.

Mr. ROY. You do how many deliveries?

Dr. GALLUZZI. Thirty-five a month.

Mr. ROY. How many surgical procedures?

Dr. GALLUZZI. I am not sure I could give you a figure right off the top of my head, sir.

Mr. ROY. I only saw 1 month, four majors and four minors. Do you agree with four major procedures in addition to four minors and 30 deliveries a month that you can do an adequate training program in this area?

Dr. GALLUZZI. I felt that way.

Mr. ROY. I have no further questions.

Mr. SYMINGTON. One additional question on the point that Mr. Kyros raised with reference to this particular piece of equipment. Was it called a cardiovascular——

Dr. GALLUZZI. Cardiovascular diagnostic X-ray equipment.

Mr. SYMINGTON. You mention that this particular piece of equipment was, as you say, not vital to your overall program. I think, being somewhat of a layman, I do recall one of the members of the staff there saying roughly 100 patients had to be denied this form of inquiry because it wasn't working. It may not be vital to the overall program, but I would have thought it might be vital to them.

Dr. GALLUZZI. I am afraid I didn't make myself clear.

I did indicate, I thought I had indicated that it is vital to our overall program in diagnosis and research; but with reference to the specific area of coronary artery disease, since we don't do that form of surgery here at the present time, it's not vital in that particular area.

Mr. ROY. Excuse me, Mr. Chairman, may I ask one more question?

Mr. ROGERS. Yes.

Mr. ROY. In this area, I understand that you are not able to do heart diagnostic work. Does this make up a large number of patients that are amendable to surgery or amendable to surgery specifically?

Dr. GALLUZZI. Yes.

As another interim measure, we have another piece of equipment which has been used for some of these cases, a portable unit that is usable. It is not the ideal.

Mr. ROY. There is some danger that the portable unit that carries the load necessary for prolonged fluoroscopy may break down; isn't this true?

Dr. GALLUZZI. That's true.

Mr. ROY. That does exactly endanger the patient to some degree if this procedure were begun and had to be repeated or discontinued because of the failure of the machine?

Dr. GALLUZZI. I believe that the equipment is used in such a way under the guidance of the expert cardiologist that we have here to assure that it's properly functioning and usable.

Mr. ROY. I was really quite impressed with the physical therapy unit and the cardiac work that you are doing, and it seems somewhat incongruous that you would have to spend as much effort and money as you do for the little obstetrics and gynecology and not be able to provide adequately for the intake area in cardiology and diagnostic work because of budgetary limitations.

As a matter of my own thinking, this did not appear to be consistent.

Mr. ROGERS. There were other representatives of HEW present at the hearing who are aware of these shortages, and the committee plans to follow up with the Department, particularly in the heart field.

I understand you are about 40 personnel short from what you would like overall?

Dr. GALLUZZI. That's correct.

Mr. ROGERS. It is my understanding there is a shortage of personnel in the coronary care unit as far as nurses, and you need more beds there?

Dr. GALLUZZI. Yes, sir. At the present time we have a staff complement of 1,060, and we feel that we need 1,100 for an adequate staff, particularly the need is in the nursing area.

Mr. ROGERS. Also, I understand equipment is needed in that area in the coronary care unit and I would hope that request would be put in, and you will let this committee know when those requests were put in and we will follow that up with HEW.

(The following memorandum was received for the record:)

MEMORANDUM—RE-EQUIPMENT FOR THE INTENSIVE CARE UNIT AND CARDIO-PULMONARY LABORATORY

Mr. Thomas E. O'Rourke, Associate Director for Administration for the Public Health Service Hospital on Staten Island provided the following information: Since the hearings in Staten Island on the Public Health Service Hospital located there, the Department of Health, Education, and Welfare has provided $35,000.00 worth of equipment for the intensive care unit and $175,000.00 for X-ray equipment for the cardio-pulmonary laboratory. Ten new positions have been added in the nursing, dietary and housekeeping departments of the hospital, bringing the total number of employees to 1,070, thirty short of the desired 1,100.

Also, my understanding is that you have a shortage of funds for supplies, that you have had to draw from other sources of funding to try to make up that shortage of supplies, some $200,000, is that correct?

Dr. GALLUZZI. That's correct.

Mr. ROGERS. Where there is an obligation by the U.S. Government by law to provide care, this committee wants to see that it is exercised properly. If the Congress is not getting the proper requests for funding this committee intends to pursue it and see why not. And I might say, too, that we intend to build the Public Health Service, not to see it torn down.

We have just passed the Emergency Health Personnel Act which calls for an expanded role of the Public Health Service. And I hope we are going to get the policymakers to get enough facts from our hearings and enough information where we could make some intelligent policy decisions which have not yet been made.

Do you have a question?

Mr. MURPHY. At the hearings this week in Washington, the question of operating bed capacity of this facility came up. The operating beds, according to the records of this hospital, are 636. However, the workload in fiscal year 1970 was 420, for a 66-percent occupancy rate.

Doctor, are you staffed to handle a workload of 636 or are you staffed to handle 420?

Dr. GALLUZZI. We are not staffed to handle a workload of 636. Our operating bed capacity at the present time with the present nursing staff is close to 500. And therefore an average daily census of 420 would be a rather respectable occupancy rate.

Mr. MURPHY. In other words, the hospital cannot operate at 100 percent of its capacity safely?

Dr. GALLUZZI. I think when a hospital gets over 85 percent occupancy rate it leads to certain inefficiencies and difficulties in the inflow and outflow of patients.

And one must also take into account seasonal variations, so there may be times when the occupancy rate would be 80 percent, other times when it would be 95 or 100 percent.

Mr. ROGERS. Doctor, thank you very much for your testimony and for your courteous help today with the committee.

The committee now will be pleased to hear from the borough president, Mr. Connor.

We are grateful for your presence here today, Mr. Connor. I know you have given testimony before, and we would like to hear your testimony today.

STATEMENT OF ROBERT T. CONNOR, BOROUGH PRESIDENT, BOROUGH OF RICHMOND, NEW YORK CITY

Mr. CONNOR. Thank you, Mr. Chairman.

Gentlemen of the subcommittee, first of all I would like to commend you for coming here to see the installation on State Island. The old trite phrase "A picture is worth a thousand words" I think could be amended to say "An onsite inspection is probably worth a thousand pictures."

I would like to compliment Congressman John M. Murphy for having the committee come here. I really think this is the way to do it, to get the facts, and I think it represents Congress at its finest.

I think it would be logical for me to be brief for two reasons. First of all, I have testified before the Senate Committee. Congressman Murphy is well aware of my thoughts in this regard. And I also have a not inconsequential item of approximately $1.7 billion to vote on in the Board of Estimate very shortly, so I am merely going to file my basic statement for the record and just comment very briefly on a few things to which I would like to invite your attention.

Mr. ROGERS. Your statement will be made part of the record.

Mr. CONNOR. It is fairly obvious any borough president has a very parochial attitude toward an installation in his borough. This installation as presently constituted employs approximately 1,060 people. In a community of 300,000 that is not an inconsequential item. On the contrary, it is probably, with one or two exceptions, the largest employer of personnel in this borough and county. Staten Island and Richmond are all used interchangeably.

Obviously, the impact of any closing would be very, very serious on our personnel situation. It would just not be a personnel situation, it would be personal tragedy for many people.

Secondly, the fiscal impact: As you can see, we are a small borough and the payroll of this institution is approximately $13.6 million annually, would be a tremendously difficult gap to close should the hospital move.

I think that Dr. Galluzzi has very capably, certainly with much more expertise than I could probably muster, addressed himself to the research facilities here, the cardiovascular, the renal, and so forth, so there is no point in being redundant and using your time on that.

As far as the training of personnel, I think that Dr. Schroeder of Richmond College, and perhaps others will indicate to you how essential this hospital is to our training program. And, again, I certainly don't have the expertise to articulate as well as they the importance of nursing programs. But you all know it and it would deal a very, very hard and severe and inequitable blow to this community should the hospital have even to be cutback, as a matter of fact, because they are doing a splendid job in cooperation with the colleges on the Island here that have these various, I will use the term generically, hospital training type programs.

I do think that the most important item is the health care of our rapidly expanding borough. The borough currently has approximately 300,000 residents. This is an increase of approximately 34 percent over the last decade and our population is continuing to increase, more or less of a bell curve situation, going up extremely rapidly. And our private hospitals on the Island are currently operating, as Congressman Murphy indicated or inferred, and I think it was a particularly good point, this hospital is operating at approximately 80 percent of capacity. It should be our interest that other private hospitals on the Island are a 100 percent, and people are in passageways, corridors, and what have you.

I won't try to paint the picture any darker than it is, but it is a very serious situation we have here.

Keep in mind, I am not particularly happy with what the city has or has not done for its residents here, but it has done very little. We do have a city hospital on the Island but it is basically or actually 100-percent geriatric oriented and is not a general hospital.

With the population curve going like this, and the hospital bed availability being down, you can see the very, very difficult situation that we have here.

I do not argue for one moment that some reorientation, call it what you will, of the mission of the Public Health Service hospitals might be appropriate. I would hope that it would not be precipitous or an abrupt type of research into the reorientation possibility. I would hope that it would keep in mind, although the Merchant Marine generally under the U.S. flag has diminished in this country, that the Port of New York—when I say that Port of New York, I take into consideration the rapidly expanding facilities, most of which of the U.S. flags in the container operations in Port Newark and particularly here on Staten Island, where fortunately our waterfront or commercial waterfront is extremely busy, being rehabilitated.

Again, mostly U.S.-flagships, and this is the one port that is having a renaissance, perhaps not as far as passenger vessels are concerned but most of them are foreign flags.

Anyhow, as far as containerization, we have roll-on, roll-off ships, the almost brand new ones that make the run down to Puerto Rico. They are not only U.S.-flag but they are being subsidized and the number of merchant seamen only in this area is not diminishing.

However, I think that the Public Health Service as well as the Congress is obligated to think occasionally about modernizing, bringing up to date the basic mission of the Public Health Service hospital, and possibly thinking in terms of some experimentation with the utilization of of the facility.

And again, I emphasize under the present framework of Federal personnel and administration or perhaps some utilized portion of the hospital, by programs of other hospitals or under medical society auspices.

But I think that it would be an area where speed is not of the essence. In other words, we should go ahead very carefully on that.

So, in essence, or in ultimation, my recommendation is to continue and to expand this Public Health Service hospital and services within the present framework of Federal personnel and administration, here and throughout the United States.

I am most grateful for what I consider the extraordinary method of this subcommittee coming to the scene. I thank you very much, gentlemen.

(The statement referred to follows:)

STATEMENT BEFORE THE SENATE SUBCOMMITTEE ON HEALTH, COMMITTEE ON LABOR & PUBLIC WELFARE—MARCH 8, 1971

Mr. Chairman: Permit me, at the outset, to commend you on taking time out of what I know is a busy schedule, to conduct this hearing on a matter that vitally affects the health and economic welfare not only of the citizens of this country but particularly of the 300,000 residents of the Borough of Richmond, of which I am President.

While I realize that your Sub-committee will be looking into the status of public health service hospitals throughout the country, my prime concern obviously is that of the Public Health Service Hospital that is located on Staten Island.

Incidentally, that Hospital is the largest of all of the Public Health Service Hospitals in the United States. It has accommodations for 636 beds and has an annual payroll of approximately $13.6 million dollars.

There are many reasons why the Public Health Service Hospital on Staten Island should be maintained and possibly enlarged as a hospital facility. The prime reason, of course, is that there is an acute shortage of hospital beds on Staten Island. At present, we have four hospitals other than the Public Health Service Hospital, operating on the Island, three of them are eleemosynary and one is proprietary.

Each of these institutions is operating at a capacity in excess of that for which it was constructed. This, in itself, creates a health hazard, since all too often patients are compelled to remain in beds located in the hallways.

In addition, doctors are constantly compelled to advise their patients who need hospitalization that they cannot be admitted since there is no space for them.

I would next like to bring to your attention, the fact that the Public Health Service Hospital on Staten Island employs over one thousand people. There is only one industrial concern on Staten Island that employs more.

While we are discussing basically the question of the degree to which the physical health of the residents of Staten Island would be affected by the closing of the Hospital, it should also be indicated that the *economic* health of

the community will be seriously affected if the Public Halth Service Hospital is closed.

Unfortunately, the City of New York in the past few years has experienced an erosion of its employment base. The elimination of the flow of thirteen and a half million dollars into the economy of The Borough would create a critical economic situation.

When I first was apprised in December of 1970 of reports that the Hospital might close down, I wrote to the Honorable Elliott L. Richardson, Secretary of Health, Education and Welfare, urging that the Hospital remain open.

Following this, on January 20, 1971 I appeared and testified at a conference arranged by Secretary Richardson at the United States Public Service Hospital on Staten Island. I clearly pointed out to Secretary Richardson's representative, the need for the availability of this Institution for hospital care.

Next, and specifically in regard to the Public Health Service Hospital on Staten Island, it is important to mention the extensive work conducted by the Hospital in the field of research.

In the late 1950's, a Cardio Vascular research program was started. Since then, a large staff of professionals with knowledge and expertise in this field, using the most advanced equipment, has performed a very worthwhile service to the country and received a national reputation for their work in the Cardio Vascular field.

Another major research program that has been going on at this Hospital, is the Renal Disease program.

While it can be argued that both of these research programs could be moved to another institution, we all realize that such a relocation, usually results in attrition in the number of personnel who will agree to relocate.

Next, I am pleased to report that the Hospital has constantly and consistently been conducting training program within a wide spectrum of health care. They include training courses for nurses, pharmacy aides, dietary internes, radiology technologists, marine physician assistants, laboratory assistants, as well as courses in manpower development training and many other subjects.

Some of these have been conducted exclusively at the Hospital, while others have been conducted in conjunction with Wagner College, Richmond College, and other institutions throughout the Island.

During the past fifteen years, over five thousand students have been trained through the services rendered by the Public Health Service Hospital.

The City, with its eight million people, cannot afford to lose this valuable training service.

Next, it should be made a matter of record that the support for the continuation of service at this Hospital has been unanimous. It includes support of the Honorable Jacob M. Javits, senior Senator from New York; Congressman John M. Murphy, of Staten Island, from whom you will hear later; the Mayor of the City of New York, and the Staten Island Advance, a Newhouse publication which has twice editorialized in favor of the retention of this Hospital.

I would be remise to merely report to you some of the reasons why this facility should not be closed and fail to suggest for your consideration, avenues that might be explored that would lead to a favorable decision to not only maintain the facility to the extent that it is needed for Federal purposes and for research and training, but also make it available for use by the general public in order that a very serious hospital bed shortage that now exists and has existed for some time on Staten Island might be relieved.

The President of the County Medical Society has already indicated that the Medical Society would eagerly look forward to the release of a portion of the facility for general hospital use.

Finally, I realize that the presentation I have made to you is in effect only a thumb nail sketch of the problem of one Federally operated hospital in the United States.

I will cooperate with your Committee and the Department of Health, Education and Welfare to the fullest extend in rendering any additional facts or information concerning the Staten Island based Hospital. I sincerely thank you for the opportunity of presenting this report.

Permit me again to express my appreciation for the concern of this Committee in looking into the problem, which is so vital to the 300,000 residents of the Borough of Richmond.

Mr. ROGERS. Thank you, Mr. Connor. We appreciate your coming here and giving us this statement.

I think many people do not realize that the Congress in this past session has passed legislation to embark on a program to build up the American Merchant Marine. The President has stated his strong support of this program, and I commend him for it, to build 30 vessels a year. This should have a tendency to build up the American-flag fleet.

Mr. CONNOR. This adds to the impact of my statement as far as our local situation here.

Mr. ROGERS. I am sure it will be reflected here in your operation.

Also, I mention that the Health Emergency Personnel Act expands the role of the Public Health Service so that they can now, by law, have authority to treat areas of critical health shortage in any area.

This, then, could help to utilize the hospital even to a greater extent.

Thank you very much.

Mr. KYROS. I want to join with you in commending Mr. Connor for his remarks.

Mr SYMINGTON. And I should like to do the same thing. Thank you very much.

Mr. ROY. I have no questions; thank you, Mr. Connor.

Mr. CONNOR. I am most grateful, gentlemen.

Mr. ROGERS. Thank you. We appreciate you being with the committee at this time.

Mr. MURPHY. In order to emphasize what the borough president said as far as need, I would ask Sister Josephine Marie and Anthony Franco to please come up to the stand.

Mr. ROGERS. Sister and Mr. Franco, the committee welcomes you. We are pleased to have you here and pleased to receive your statement.

Mr. MURPHY. Would you lead off, Sister, and explain the assistance this hospital gave you?

STATEMENTS OF SISTER JOSEPHINE MARIE, ST. JOHN THE BAPTIST ORDER, STATEN ISLAND, N.Y., AND ANTHONY FRANCO, FORMER PATIENT, U.S. PUBLIC HEALTH SERVICE HOSPITAL, STATEN ISLAND, N.Y.

Sister JOSEPHINE MARIE. My brother became ill——

Mr. ROGERS. Would you identify yourself?

Sister JOSEPHINE MARIE. I am Sister Josephine Marie, St. John the Baptist Order. I have taught and I am presently at an academy as a reading coordinator.

My brother got ill last year in February. I am sorry we didn't take pictures to show what my brother looked like compared to the way he looks today. We did not know that his kidney had failed and he went into uremic poisoning. Since he served 20 years in the army, we didn't have money to put him into a hospital. So, the best thing to do was to take him to the Veterans' Administration. He went to Fort Hamilton.

After my brother was there for 3 weeks, just in bed, I should say, they found out that he had this poisoning. He had scabs all over his body, his legs were all full of open wounds and oozing from all sides. Blood was coming out of his mouth. He was at the extreme where he was going to die.

After they had him there for 3 weeks, they didn't have the hemodialysis machine my brother is on now. They thought they could do this through a system of a hole through the stomach. When they found it didn't work, my brother got an abcess from it.

Then they made it known to the family, my sisters and myself, that the only way that my brother would be able to live was to get him on a kidney machine.

I don't know where to go for a kidney machine except my family didn't have the money to pay for this. So I had Mrs. Rose Marie Battista—her children are now at school at St. Rock—when she called me up I found out how serious my brother was and I broke down talking to her. And she asked me why.

I told her my brother hasn't got a chance to live because we need a kidney machine. She said "Sister, leave it to me. I will see if I can get my father to work with Congressman Murphy on the Island to get him into the U.S. Public Health Service Hospital."

Within a matter of hours, I talked to Mrs. Battista on Saturday morning at 9, by 3 o'clock I had received a call at the VA hospital to transfer my brother to the U.S. Public Health because they had no hopes for my brother there any more.

I immediately got an ambulance because the VA said I couldn't have an ambulance from their hospital because they weren't transferring him; I had asked for this. I signed papers taking his life into my hands.

I got here at the U.S. Public Health hospital at 3 o'clock, and we reached here at 6 because I had to wait for the hospital. There was a staff, because my brother was in a coma, and didn't know what was going on, of from seven to eight doctors around his bed, and nurses. They had never seen a case like my brother's. They all were there to help him.

Naturally, I stayed there and asked the doctors if there was any hope. I could see by their faces that my brother didn't have a chance. But I left him in God's hands, and in the good hands of the doctor, and left the hospital about 10:30.

Then I heard they called the doctors about 11 o'clock at night and said to commence to start taking the poison out of my brother's system. They put him on the machine, and the same night that he arrived here he was put on the kidney machine from there on.

Today I think we owe his life, to see him walking and see him functioning as a man, to the excellent staff at the U.S. Public Health Service hospital. If it wasn't for them and Congressman Murphy opening my eyes and making the leeway to come here I wouldn't have a brother today.

Mr. ROGERS. Thank you, Sister.

Mr. Franco, would you like to make a statement?

Mr. FRANCO. I think my sister has covered most of what happened.

The 3 weeks I was in the Veterans Hospital I just lay there and the statement from one doctor was he hoped they had a kidney machine in the hospital. They didn't have any, so they would try their best.

I laid up in the intensive care unit there. They told me with this hole in the stomach I was only supposed to last 48 hours and I laid up there from Tuesday to Friday. Because every time it stopped

running the nurse said we have no other doctor who knows what to do. We have to wait until your doctor comes in the next morning.

And I had to stay there with this thing in my stomach until the next morning until the doctor came in again, and he pulled it out and jabbed it in again right in the same spot. He did it four times, then I understand there was an abscess in the stomach.

Mr. ROGERS. Do you come back for a dialysis each week?

Mr. FRANCO. I come here three times a week on the dialysis machine.

Mr. ROGERS. You look fine, and we think they are doing a good job. I think that is a real tribute to the hospital here.

I thank you.

Sister JOSEPHINE MARIE. He is supposed to be on the machine now.

Mr. ROGERS. We won't detain you.

Mr. MURPHY. Mr. Holtmeyer, the branch development director.

FROM THE FLOOR. I am not Mr. Holtmeyer, but he did testify in Washington early this week and felt that today should be a day to hear from the community.

Mr. ROGERS. Thank you.

We did hear from Mr. Holtmeyer and his testimony was most helpful to the committee.

Mr. MURPHY. Assemblyman Louis Russo.

Mr. ROGERS. Mr. Russo, the committee welcomes you and appreciates your being here to give us the benefit of your thinking.

STATEMENT OF ASSEMBLYMAN LUCIO RUSSO, MEMBER, NEW YORK STATE ASSEMBLY, STATEN ISLAND, N.Y.

Mr. RUSSO. Thank you very much. I appreciate your being in my assembly district.

I am going to be very brief and not repetitious.

I understand, of course, that the Federal Government and many State governments are engaged in budget cuts, especially this year. The hearings scheduled in New York are to make tremendous cuts, and probably Washington is doing the same thing.

But what amazes me all the time is the area where cuts are proposed, and some of the charades that we all go through in proposing cuts.

I was also amazed, of course, when we sent a man to the moon, for example, and when we sent other men at other times. But it seems to me that there should be some sort of order of priorities. It is very fascinating to see men land on the moon and pick up a few stones, but that's an area where if we have to make cuts we should make cuts since we are so far ahead of any other nation.

But it seems to me when we get into the area of public health it is something else. It is an area they should be expanding because certainly the Government owes a duty to the people to keep their health in good order. And here with the potential of cuts in the Public Health Service we are actually engaged in semantics and I am not one to criticize the Nixon administration as a member of my party, but nevertheless, I think we all make errors at times in the setting of priorities.

I say it's semantics for this reason. Since we have these obligations under medicare and medicaid it seems to me that whether money is spent here or spent in other hospitals on Staten Island, in the last analysis the taxpayers are paying for it.

As far as our hospitals on Staten Island, we have one proprietary hospital and three voluntary hospitals. They are overworked to begin with. You have to wait literally weeks for a bed. And here we have such wonderful facilities and you hear threats of a beautiful hospital such as this being closed.

It seems to me that if there is any overflow of patients from other hospitals, they should be here, especially the elderly and the sick and those on welfare to take care of their needs. Because, as I said before, we pay for it in one form or another. And why they are engaged in these semantics, I don't know.

I just wanted to make that point, gentlemen, that this is an area I never believed in cutting. It's an area that should be expanded. We could cut in many other areas that are not vital to the health and welfare of the people. Certainly, this is an area that is very vital to the health and welfare of the people.

Mr. ROGERS. Thank you, Mr. Russo. I certainly agree with that and this committee in holding hearings is trying to point up the problem, to get the administration to reset some priorities in the health area. We hope we can be successful, and your testimony will be most helpful in that regard.

Mr. RUSSO. I hope so.

The letters I receive from taxpayers show they are certainly concerned about additional taxes, and so on, but I have never in 20 years in serving in the State legislature ever received a letter for a cutdown on public health. They talk about welfare programs or defense or excursions to the moon, but never once have I received a letter to cut public health, to cut anything that concerns the health and welfare of the people. I never heard of that.

Mr. ROGERS. Thank you. We are grateful to you for being here.

Mr. MURPHY. Mr. Alvin Zeidel, National Maritime Union director of hospital service. He is accompanied by Frank Toohey, who is their representative for Government operations, and Emil Yoseiba and Willard Quick, Local 33 of the National Maritime Union.

They have presented their statement to me and I would ask that this be received.

Chairman ROGERS. Without objection it will be made a part of the record. We are grateful for their statement.

(The statements referred to follow:)

STATEMENT OF ALVIN ZEIDEL, HOSPITAL AND SOCIAL SERVICES DIRECTOR, NATIONAL MARITIME UNION AND ANDREW RICH, ASSISTANT BUSINESS MANAGER, NATIONAL MARITIME UNION

Gentlemen, speaking in support of a position arrived at keeping open the U.S. Public Health Service hospitals, we have observed the Public Health Service hospitals came under attack during the opening days of each new administration. Despite the program's origin back to 1798, the Bureau of the Budget in the past and the Office of Management and Budget today seem to find some strange reasons to keep their attacks on this great program.

The Public Health Service hospital system has provided medical care for merchant seamen, coastguardmen, and other beneficiaries for many years. This system has been tested for 173 years and passed the tests with adequate testimonials to its great work in helping to protect our Nation against imported disease catastrophes. Furthermore, it has established and maintained a public service concept that has benefited the medical profession by providing good training to young medical and dental professionals.

In working toward solving the current shortage of hospital beds in our Nation, the PHSH system provides some 2,500 beds. The system is staffed by 5,300 people. In addition to the nearly 300 physicians, dentists, and interns in training, the system provides employment opportunities and training to nurses, dieticians, specialized medical librarians, X-ray technicians, and pharmacists. Also, approximately $6 million a year is invested in research programs.

It is a misstatement to say that merchant seamen and other beneficiaries could be adequately cared for in other community hospitals and Veterans' Administration hospitals. We are well aware of the nationwide shortage of hospital beds in American communities both in cities and rural areas. It is also well known that the VA hospitals have long wartime lists and are now appearing to feel budgetary pinches which are resulting in inadequate care in too many cases.

The veterans organizations strongly support the Public Health Service hospital system. They, and we acknowledge the need for this system which should continue to be supported and not curtailed. I thank you for the opportunity of presenting to you the views of our organization which represents 50,000 merchant seamen.

STATEMENT OF FRANK TOOHEY, GOVERNMENT OPERATIONS, NATIONAL MARITIME UNION

As the representative of the National Maritime Union I would appreciate if the following facts could be entered into the record.

1. That 40.5 percent of the employees at the USPHS Hospital, Staten Island, are from minority groups and it is a matter of record that the U.S. Government is spending millions of dollars to train said groups. It would be a waste of taxpayer's money to close the hospitals which would result in trained people being out of work.

That 95 percent of the workers at the hospital live on Staten Island and it would only add to the unemployment rate in that area.

Mr. MURPHY. Councilman Frank Biondolillo.

Mr. ROGERS. Councilman.

STATEMENT OF COUNCILMAN FRANK BIONDOLILLO, NEW YORK CITY COUNCIL

Mr. BIONDOLILLO. Mr. Chairman, Congressman Murphy and other distinguished members of the committee.

I would like to note that Congressman Symington's musical and entertainment abilities have preceded him to our great borough.

I am not going to bore you nor be repetitive with a volume of statistics. I think Mr. Russo read my statement before I got here, so we are going to repeat a few of those things that he had to say.

Gentlemen, we shouldn't even be considering a closing down of this facility or the transferring of any of its responsibilities. The Federal Government should be talking in terms of rehabilitating and enlarging this facility.

We hear of many new health and research programs that will assure medical care for most persons and we have medicare and medicaid, and talk of universal health insurance, increasing the number of grants for physicians and surgeons and nurses and other paramedical personnel care, care for the aged and the indigent, and this is all well and good.

But where are we going to treat these people? Especially in view of the fact that all of our hospitals right now on Staten Island and many other places in the country are overextended. God forbid any of us should be seriously stricken in the next few hours but we would find ourselves in a hospital corridor. I have seen this happen many

times, for emergency treatment. It isn't the most dignified thing to see a person dying in a hospital corridor because of lack of space.

There are thousands of aged right at this point waiting to get into hospitals and homes. I don't think we ought to forget these people who contributed a whole lifetime to our democratic system.

I think we should be talking in terms of maybe establishing a national geriatric and research center to study and control geriatric disease and rehabilitation. And I think we ought to be thinking in terms of expanded care—both inpatient and outpatient care—for the medically indigent.

We should be talking about the expanding of the specialty treatments afforded by this institution, not otherwise available in other areas.

I might say I had a young brother die last year, 39 years of age, in a veterans hospital because of the lack of a dialysis machine. I am just sorry he wasn't in this area where he could be treated.

Right now one of our hospitals is in serious financial trouble; and Congressman Murphy and myself and some of the other people who were over at St. Vincent's Hospital, they are seriously considering cutting out the ghetto medicine clinic which will affect approximately 9,000 patients.

What I am trying to say is, don't give us expanded coverage and guarantee that our people will all be able to afford adequate medical and surgical treatment, and then not provide the facilities for that treatment.

As Mr. Russo said, I am a little disappointed that this administration is contemplating the closing down of this facility. I am sure that there are ways that we can utilize a public-private contractual agreement to help defray mounting hospital costs, but we need our hospital.

I, too, get a litle disgusted with the overuse by many of the word "priority." We hear all this rhetoric concerning ABM's and SST's and NASA's and BC's. I am sure they all have their place and priority, but as far as I am concerned all those letters should follow USPHS in our economic priority alphabet.

I am sure there are those who say we can't afford to keep this facility open, but, gentlemen, we can't afford to close or phase out this facility. If we can afford to subsidize agriculture, airlines, oil, highways, housing, we certainly can subsidize life and health and physical comfort.

Thank you.

Mr. ROGERS. Thank you very much, Mr. Councilman. We appreciate that statement.

Mr. Kyros?

Mr. KYROS. Mr. Chairman, I only wish to say that I am glad that we are able to hear witnesses who don't feel inhibited about discussing policy. [Laughter.] Apparently the only people who are not allowed to discuss it are the people who work here. Of course, what do they know? [Laughter and applause.]

Mr. BIONDOLILLO. Again I want to thank you gentlemen, and Congressman Murphy for his efforts in this field.

Mr. ROGERS. Thank you so much.

Mr. MURPHY. I am going to ask several witnesses to come up and join us at the witness table: Bill Harris, Midian Quinones, Hank Pedro, Bernice Moore, Leroy Thompson, and Arlene Gannon.

Mr. ROGERS. We welcome you and ask each of you to identify yourselves for the record. Tell us your name and what you do.

STATEMENTS OF ARLENE GANNON, FAMILY ASSISTANT TO HEADSTART PROGRAM, NEW YORK CITY; MIDIAN QUINONES, VICE CHAIRMAN, HEADSTART PARENTS COMMITTEE, STATEN ISLAND, N.Y.; BEN HARRIS, REGIONAL ASSISTANT MANAGER, MANPOWER REDEVELOPMENT AGENCY, NEW YORK CITY; AND LEROY THOMPSON, CHAIRMAN, NORTH SHORE HEALTH COUNCIL (REPRESENTING HANK PEDRO, STATEN ISLAND COMMUNITY COOPERATION OFFICIAL, CAP AGENCY FOR STATEN ISLAND)

Miss GANNON. Arlene Gannon, family assistant to the Headstart program served by the hospital.

Mrs. QUINONES. My name is Midian Quinones, vice chairman of the PCC Headstart program.

Mr. HARRIS. Ben Harris, regional assistant manager for the Manpower Redevelopment Agency of the city of New York.

Mr. ROGERS. We are pleased to receive your testimony.

Mrs. QUINONES. I am here representing the parents of Headstart. We strongly oppose the closing of this service like most Staten Islanders do, but our reason is that our children attend this hospital for physical exams through the school. And we finally found a facility where our children receive thorough and proper physical examinations by a sensitive staff. And from my own experience, I live on the Island, I haven't been here very long, I say this.

The medical facilities here leave a lot to be desired sometimes.

I am on public assistance, and a few months ago the medicaid records were changed. Unfortunately, somehow along the line, mine was lost. I have five children, two of which were very, very ill, and they had no place to go. And I went to the hospital. The doctor saw them, gave me a prescription. I am stuck with a prescription that I cannot do anything with.

I remember having Dr. Sterner coming to the parents of Headstart and tell us that the children would be seen on an emergency basis at the emergency room.

This was really the only place I could go to. They did give me the medical assistance I needed and medication for the two children.

We have several mothers in the program whose only recourse at the end of going through everything else have had to come to the hospital, being the only place they could get this assistance.

In view of all this and the help we are getting from them, this is why we oppose it.

Thank you.

Mr. ROGERS. That's a very pertinent statement. And it is the intent of the Congress and legislatiton we have just passed that the Public Health Service become more oriented to community service. We have now the authority in law for them to do that, and I am glad to see this hospital is already doing something.

Mr. HARRIS. Mr. Chairman, Congressman Murphy, other distinguished members of the subcommittee.

In spite of the limit of resources and short staff of this hospital, I believe that it is doing the best it can, as always, to provide services to the community.

Previously, I worked in the area of manpower. This hospital administers physicals for people in our manpower program.

When I took office about 2 years ago I was very much concerned about the fact of outside trained people for jobs for a period of 20, 24-weeks and finding out at the end of the training that these people had some kind of a medical problem where they would not be able to be employed.

So, I was very much concerned with that and I approached my commissioner at MCP and we made an agreement with Dr. Gallnzzi and the members of his staff and they extend the service to us at a very minimum fee. We were not able to get this service from any other facility on Staten Island. And needless to say that by the fact they have been giving us physicals has really enhanced my ability at the training cycle of our clients.

I would like to say the closing of these facilities will seriously affect our medical community and also be a great loss to the manpower needs of Staten Island.

The borough president alluded to some of the comments I wanted to make, so I support the borough president's comments on manpower problems if this hospital were to close.

I would also like to indicate I do support the efforts of Congressman Murphy and other political leaders here in order to keep these facilities open. I guess I am somewhat prejudiced about the closing of the hospital. I feel very close to it because my first son was born here when I was in the Air Force. So, that's one of the reasons.

But I don't want to be selfish in my opinion. I would like to see the hospital remain open because it is providing wonderful service to our community.

Thank you.

Mr. ROGERS. Thank you so much.

Miss GANNON. Perhaps I should make a small statement. In 5 years working with the Headstart program I was primarily with parents who are welfare recipients and who have been going to various clinics on the Island. If we can hope now that the Public Health Service wil indeed stay open and if it will make its services available to th community, my hope is that we will learn from past experienc and not have this clinic facility become overcrowded and overburdenel and short staffed, so that ultimately they cannot give the fantastic service they have been given to our families. I think that's very important.

I think the clinics we have on the Island don't want to give good care. I think they are just too harried and I think that in the planning and policy making we must concern ourselves with that practical consideration.

Mr. ROGERS. Thank you very much.

Mr. KYROS. How many children in the Headstart program are involved in taking their physical examinations here?

Mrs. QUINONES. Sixty-two.

Mr. HARRIS. I would also like to add in the course of a year our service trains somewhere between 800 and 1,000 people.

Mr. ROGERS. All of these are given physical exams here?

Mr. HARRIS. Where we detect there may be some medical problems we send them here.

Mr. ROGERS. Would you identify yourself?

Mr. THOMPSON. Leroy Thompson, representing Mr. Henry C. Pedro, executive director, Staten Island Community Cooperation, CAP Agency for Staten Island. I am also chairman of the North Shore Health Council. Might as well get this in, too, chairman of the Family Day Care Center as a profit program.

And the beginning of this program was when I first started working with Dr. Galluzzi and his staff here.

Last year we had 450 children from poverty programs and poverty areas examined in this hospital, 30 percent of which are still receiving followup care here. We had 250 adults that were examined here and at least 25 percent of them are still receiving followup care.

There are no funds available for these people. They fall in the income bracket where they were not eligible for medicare or medicaid and the medical facilities on Staten Island were just not able to handle them and you can't put them in a program like this unless they do have these medical examinations.

In the poor areas and not so good poor areas we have a problem with people being hospitalized and their resources being exhausted. These people have no place to go. Here in Public Health they have been treated and followed up and have been well taken care of.

I heard Dr. Galluzzi speaking of the transcribers' program on the physicians assistants program. Eighty percent of the people that were put in the transcribers' program were welfare recipients, female. From our program alone we put 20 percent of the physicians assistants in that program and all of them were unemployed at the time.

Mr. ROGERS. What was that figure of how many were put in the physicians assistants program?

Mr. THOMPSON. We put 20 percent of the people in the physicians assistants program.

I heard somebody talking about OB. In the case OB, and to be short staffed, but in ghetto neighborhoods or low-income neighborhoods I would say with the problems that we get in one day, this program definitely needs to be expanded.

Money is a problem. I hope that the training programs can be expanded to cover programs that we now have in the makings as a community service aid program. I think HEW has had them over a year now in connection with the community college.

We want to get these programs started and these people will end up from welfare with an associate's degree in community service.

There is one other program that we have been desperately trying to get here to kind of take the pressure from the male poor population, the inhalation therapy training. In spite of all the community colleges, Dr. Galluzzi, the hospital staff and the CAP Agency, we have not been able to get the funds for this.

On Staten Island at the present time there are only two registered inhalation therapists. After midnight it is almost an impossibility to get blood and gases in heart cases. As a doctor, you know these things are very, very important.

In connection with Public Health I don't have any complaint at this time about the type of services they have given except they just don't give enough. And, of course, money is the cause for this.

Personally, I am sitting here as one of the luckiest men ever alive. I am being followed at the hospital myself. I had an aneurism and a cerebral hemorrhage and I am sitting here all in one piece, no ill effect at all. I am being followed by the cardiac section in this hospital.

Mr. ROGERS. That certainly speaks well of the hospital. You look mighty healthy. That's wonderful.

Your prepared statement will be placed in the record at this point.

(The statement referred to follows:)

STATEMENT OF LEROY THOMPSON, CHAIRMAN, HEALTH COMMITTEE, STATEN ISLAND COMMUNITY CORPORATION, AND HENRY C. PEDRO, EXECUTIVE DIRECTOR

The Staten Island Community Corporation which is the official C.A.P. Agency for Staten Island opposes the closing of the U.S. Public Health Hospital in Clifton. The closing of this hospital would have a great impact on the lives of those community residents on the North Shore of Staten Island, those who are medically indigent, those who are on waiting list awaiting surgical beds and those who have or will utilize community oriented programs. The hospital has been very significant in helping the three voluntary hospitals on Staten Island whose surgical beds and In-patient Clinics have been crowded for many years, ever since the Verranzano Bridge was constructed.

The Community Action Programs of Staten Island have been deeply involved and dependent on the U.S.P.H. Hospital for referrals for the medicallly indigent poor and minority groups. They have provided the full medical examinations for the children who are partielpants in the federally funded Silver Lake Lodge #59 Family Day Care Center and the Staten Island Mental Health Headstart Program. The number of children examined by the medical staff of U.S.P.H. Hospital for the Family Day Care Program since 1969 is 470 and the number of adults is 180. Of each group five needed hospitalization. Of this group at least 30% have been followed through the outpatient clinics for conditions as minor as colds to congenital heart defects. The Headstart Program has had eleven referrals to the hospital since December 1970.

A large number of Staten Island's citizenry has received services from U.S.P.H., when their health insurance coverage has ended and all other assets have been exhausted.

The U.S.P.H. Hospital is the only testing facility for lead poisoning of children on Staten Island. Right now the hospital is proposing to examine every preschool child getting ready to enter Headstart.

There have been many community residents who were formerly on public assistance that have taken advantage of training programs geared towards meaningful employment in the medical field. One half of the marine physicians assistants trainee programs participants are poverty area residents, 80% of the participants in the medical transcriber programs that began last September were on public assistance.

There are at present approximately 1,100 employees at the U.S.P.H. Hospital. Over half of those would be knocking on the doors of the Social Service Department the day after the closure of those facilities. Unfortunately, the employment opportunities in Staten Island in the medical institutions are very negative and would not be able to accommodate such a large number of unemployed. The public assistance rolls on Staten Island have already increased from 6,000 to 10,000 during the past three years.

There are many family situations involved at the hospital; husbands and wives who are employed there with family responsibilities who would most assuredly depend on public assistance in order to survive if the hospital were to be closed.

Presently, Staten Island is facing a situation of being in a state of a lack of medical facilities. One of our major hospital services, Staten Island Hospital is moving to the South Shore of Staten Island which will place a tremendous hardship on the residents on the North Shore. The U.S.P.H. Hospital is the only institution in the area that could take up the slack. In our City Health Department we are confronted with a situation of not having a full time Health Officer in an office that is supposed to service the total population of Staten Island and also initiate new programs to combat our health indices. We have just recently lost our Health Educator who was stationed at our local health center. Now the only Health Educator working on Staten Island is em-

ployed by the U.S.P.H. Hospital. Only a handful of private doctors on Staten Island subscribe to the medicaid program which is widely used by the poor and minority groups to subsidize their medical needs.

In a recent survey conducted by Urbach Associates, retained by the Borough President, they state that Staten Island will be facing a "critical situation" in the future if careful health planning is not undertaken.

The Staten Island Community Corporation opposes any form of hospital other than the U.S.P.H. Hospital because a new hospital would not be able to offer the type of services that U.S.P.H. Hospital is offering and potentially able to offer.

Mr. ROGERS. Thank you so much. We appreciate this to know of the community involvement and the importance you attach to this hospital and it will be most helpful to the committee.

Mr. MURPHY. Mr. Aldo R. Benedetto?

STATEMENT OF ALDO R. BENEDETTO, REPRESENTATIVE CHAIRMAN, AD HOC COMMITTEE OF CONCERNED CITIZENS, STATEN ISLAND, N.Y.

Mr. BENEDETTO. I come before you distinguished members of the House Subcommittee on Public Health and Welfare as the representative chairman of an ad hoc committee of concerned citizens to maintain the U.S. Public Health hospital at its present status. I appeal to this committee today. We also hope you will institute an expansion program for the betterment of extensive medical care, research, and teaching.

Because you will be hearing from many speakers representing various organizations, I will direct my appeal to one specific facet—veterans. On behalf of the quarter of a million members of the State of New York American Legion; as a dedicated spokesman of the executive committee of the above organization; on behalf of all the veterans of this county; as the executive chairman of the Memorial and Executive Committee of Richmond County, which comprises all the veterans organizations on Staten Island, I urge you to give us intense, concerted thought to our plight.

You might know that the national organization of all the veterans organizations are on record with HEW as being opposed to the closing of this hospital. On the State level all the veterans organizations foresee disaster if the hospital is closed. Every veterans organization on Staten Island has passed resolutions opposing the closing of this institution. I attach as part of the record the resolution sent to the President of the United States, the Secretary of HEW, and the congressional delegation from the State of New York.

Many erroneous remarks have been made by Secretary Richardson before various congressional committees regarding the closing of the U.S. Public Health hospital here. The classic remark he claims, stated to Donald Johnson, Director of the Veterans' Administration, said that room could be found in VA facilities to accommodate former patients of the Public Health hospitals.

However, the American Legion, Department of New York, has on file, and I have a copy of the letter with me for your record, a letter sent from Director Johnson stating that at no time did he ever make such a statement. Furthermore, he said that his only remark to Secretary Richardson in answer to his question was that a study of the

facilities would have to be made and he added in our letter that at the present time the VA was operating full capacity and therefore it would be impossible to accommodate any additional patients.

His report shows that all the veterans hospitals in Manhattan, Bronx, East Orange are filled to capacity. They can go to a local hospital, you might say. But you also hear from many of the other speakers that the hospitals on Staten Island are so crowded that patients are bedded in the halls.

I will repeat my question: Where will the veteran go? During a series of dire emergencies they served their country. Some came home sick or disabled; but thank God, they returned to their own Staten Island. Now, 25 years later, the country he served so well is considering taking away the necessary means to his well-being. Yet, the Government feels it is no longer responsible to care for these veterans. The Government wants to close down this most vital, necessary facility.

Consider another factor. What about the employees of the hospital? So many of them are veterans of World War II and Korea. Do not the powers that be feel any obligation to maintain their jobs or would they prefer to see them join the ranks on the welfare files or perhaps they would rather have them collect unemployment insurance? Our President in his message to Congress answered—and to the Nation—pledged that health and medical care was one of his main concerns during his administration. We cannot see how closing the much needed U.S. Public Health hospital here in Staten Island could help the sick veteran or the veteran who earns his living working for the benefit of those sick or disabled veterans.

Another question arises in this crisis: Where would the retired personnel of the Army and Navy, Marines, and Coast Guard and other services go for their medical needs? How about their dependents? What shall happen to those in service who are currently serving and doing their tour of duty on Staten Island or in nearby hospitals or installations, and their dependents?

As I understand, they will not have the U.S. Public Health hospital to go to; they will have to engage private physicians. If dependent, they would have to resort to such local clinics as their income is very limited. As a result of the closing down of the U.S. Public Health hospital I am afraid we would have many sick people on our hands brought about by a lack of competent and required medical care.

I cannot really believe that our country has grown so callous and disinterested in the veteran and his dependents. Let us not forget most of the young men we have fighting, some dying, being wounded for us in Vietnam, and other foreign shores. Will they be forgotten, too, when they return and are in need of medical treatment in a Veterans' Administration hospital? Will they say to them, "Sorry, you will have to go elsewhere for help"? HEW decided the U.S. Public Health Service hospital on Staten Island wasn't too necessary.

I plead with this body to consider the plight of community needs, the serviceman's needs, the veteran's needs, and employee's needs.

We would recommend an expansion of this fine and renowned insituation, expanded in the number of beds, expanded in its facilities, expanded in its teaching, and expanded in its research.

Thank you very much for your very kind invitation to appear before you.

(The attachments to Mr. Benedetto's statement follow:)

RESOLUTION OF AMERICAN LEGION OF RICHMOND COUNTY (STATEN ISLAND)

Whereas the United States Public Service Hospital (hereinafter called the USPHS Hospital) and its predecessor institutions have been an important segment of the community of Staten Island for over one hundred seventy years; and,

Whereas, news media have reported the proposed closing of the USPHS Hospital; and,

Whereas, Secretary of Health, Education and Welfare, Elliot L. Richardson has confirmed the Nixon Administration is considering closing the USPHS Hospital on Staten Island; and,

Whereas, the closing of the USPHS Hospital will reduce the number of available hospital beds on Staten Island by 600, or approximately twenty-five percent of the total available hospital beds on Staten Island, even though there is a dire need for more hospital beds on Staten Island; and,

Whereas, the USPHS Hospital provides practical medical training for hundreds of students of three Staten Island colleges who are studying for degrees in the fields of surgical, obstetrical, pediatrical and medical nursing, practical nursing, laboratory technology, bacteriology, medical technology and medical transcription and the closing of the USPHS Hospital will deprive these hundreds of students of facilities to readily further their educations in medical fields at a time when there is a critical shortage of trained medical personnel; and,

Whereas, in the event the USPHS Hospital is closed, an additional one thousand one hundred employees will lose their jobs and will be added to the large number of workers currently unemployed on Staten Island; and,

Whereas, many of these unemployed hospital workers will be eligible for unemployment insurance and welfare benefits with the resultant increase in government expenditures for these very costly programs; and,

Whereas, in the event the USPHS Hospital is closed, many employees will forfeit equities in pension, life insurance and health plan benefits which they have accrued through many years of loyal, faithful, dedicated service to the hospital and the Government of the United States; and,

Whereas, many of the employees at the USPHS Hospital are over fifty years of age and, in the event the USPHS Hospital is closed, will find it almost impossible to get gainful employment; and,

Whereas, the severely depressed economy of Staten Island cannot absorb an additional loss of thirteen million dollars disbursed annually for salaries, services and supplies at the USPHS Hospital; and,

Whereas, hospitals in the New York area are operating at ninety-five percent of capacity and, in the event the USPHS Hospital is closed, cannot take care of the additional load of patients now serviced by the USPHS Hospital such as merchant seamen, armed forces personnel and their dependents, Coast Guard personnel and their dependents, disabled and ill veterans, federal government employees who are injured in line of duty and emergency cases in the immediate community;

Therefore, be it resolved that the American Legion of Richmond County (Staten Island) in executive session assembled on the eleventh day of January in the year of our Lord one thousand nine hundred and seventy-one, unanimously voted to vehemently oppose the suggested closing of the USPHS Hospital on Staten Island, New York; and

Be it further resolved that the Congressional delegation from the State of New York be called upon to prevent the closing of the USPHS Hospital on Staten Island: and

Be it further resolved that President Richard M. Nixon be informed of the full impact the closing of the USPHS Hospital will have on the health, education and welfare of the three hundred ten thousand people residing on Staten Island, New York; and

Be it further resolved that President Richard M. Nixon be petitioned to cancel any and all plans for closing the USPHS Hospital on Staten Island, New York.

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., January 26, 1971.

Mr. MAURICE STEMBER,
Department Adjutant, the American Legion,
Department of New York, New York, N.Y.

DEAR MR. STEMBER: I am pleased to reply to your letter of January 14, concerning the possible closure of the United States Public Health Service Hospital in Staten Island, New York.

The Department of Health, Education and Welfare approached me some time ago to determine whether or not the Veterans Administration would be willing to cooperate with that department should a decision be made to close certain Public Health Service facilities. At that time, I expressed to Secretary Richardson our willingness to cooperate with his Department to the extent possible.

I can assure you, however, that under no circumstances could we agree to provide medical service to beneficiaries of the Public Health Service or, for that matter, any others when to do so would interfere with the care and treatment of veterans.

So far as I personally know at this time, no final decision has been reached by HEW regarding the possible closure of certain of their facilities. I will keep all service organizations fully advised regarding our plans in connection with this matter as soon as a decision is reached.

Sincerely,

DONALD E. JOHNSON, *Administrator.*

Mr. ROGERS. Thank you so much. Your statement is most helpful. We appreciate your presence here.

Mr. MURPHY. Dr. Schueler, president of Richmond College. I am going to ask Dean Fitzpatrick from Staten Island Community College to join him.

Mr. ROGERS. Dr. Schueler, welcome, and Dean Fitzpatrick, we welcome you, and you might identify yourselves.

STATEMENTS OF DR. HERBERT SCHUELER, PRESIDENT, RICHMOND COLLEGE, CITY UNIVERSITY OF NEW YORK; DAVE FITZPATRICK, DEAN, STATEN ISLAND COMMUNITY COLLEGE; AND DR. EDITH KIRSCHNER, PRESIDENT, DEPARTMENT OF BACTERIOLOGY, PUBLIC HEALTH, WAGNER COLLEGE, STATEN ISLAND, N.Y.

Dr. KIRSCHNER. I am Dr. Edith Kirschner, president of the Department of Bacteriology, Public Health, Wagner College in Staten Island.

Mr. ROGERS. Thank you, Doctor.

Mr. FITZPATRICK. Dave Fitzpatrick, Staten Island Community College.

Dr. SCHUELER. Herbert Schueler, president of Richmond College.

Perhaps I should start by indicating I am here on behalf of the two public colleges on the island, both units of the City University of New York. One is the Staten Island Community College and the other is Richmond College. I am speaking on behalf of the board of trustees of the two colleges under the chairmanship of Prof. Arleigh Williamson, a long-time resident and civic and educational leader of this community.

I am also speaking on behalf of the many faculty members and many students who have experienced this hospital, literally, as an extension of the campus of each of the two institutions in the various programs

of training and consultation that we have been able to mount with the help of the public health.

We consider this hospital to be a superb teaching hospital, something that is sometimes underestimated, and unsung in the work this hospital has done. It is a superb teaching hospital largely because of its full-time residents, highly qualified professional staff, which is a rather unusual phenomenon in a hospital.

These staff members, under the able guidance of Dr. Galluzzi, work with us not only here at the hospital where students are assigned in various capacities, but also work with us on joint committees for the development of new programs like, for example, a new environmental health training program, but they also work with us as adjuncts to our teaching staff. And we have discovered, not to our surprise, but it was obvious that these are not only superb scientists and physicians but capable teachers as well.

Dean Fitzpatrick has more of the details of our involvement and I would like him to continue.

Mr. ROGERS. Thank you very much, Doctor.

Dean?

Mr. FITZPATRICK. I just want to express my appreciation and thanks at being able to come here and tell you about our relation with the Public Health hospital.

The Staten Island Community College is a unit both of the City University of New York and the State University of New York. We have presently enrolled approximately 8,000 students. Of this 8,000 students approximately 500 are directly involved with this hospital.

We have altogether about five programs operating in conjunction with the hospital now. They are the 2-year associate degree registered nurse program, the medical laboratory program, the community service technician, the environmental health program that Dr. Schueler spoke of, and medical transcriber program which was mentioned before in earlier testimony.

In addition to that we have two programs in development which opened this year and these are the orthopedic assistants program which will be entirely composed of returning medical corpsmen and a dental assistants program.

As Mr. Jones mentioned before, that dental assistant program likewise will draw many of its candidates from the disadvantaged groups on Staten Island.

Now, these some 500 students spend variously in the different programs anywhere from 100 percent of their time in this hospital under the tutelage of its administration and staff down to as little as 20 percent in a few cases. I estimate that at any given working day approximately 200 of our students are in the hospital here.

I will be very brief. I would like to pass this over to the secretary to be included if it suits you. And I have testified previously at the other hearings but I would like to say that the loss of the services of this hospital would force an abandonment of these programs and the curtailment of others. We have no choice.

(The item referred to follows:)

STATEN ISLAND COMMUNITY COLLEGE, FALL 1971

Curriculum or programs	Total students in program	Student-hours per year in USPHS	Average number of students daily in USPHS	Allotted space in USPHS
Nursing	550	32,640	60	2 classrooms (including 1 laboratory), 1,600 square feet. 3 rooms for dressing, 1,200 square feet.
Medical laboratory technician	105	30,000	25	Conference rooms on various ward areas when available.
Medical assistant				1,000 square feet.
Orthopedic assistant	33	10,890	33	3,000 square feet.
Environmental health	15	5,200		
Dental assistant	30	18,000	30	Do.
Medical transcriber	40	20,800	20	1,080 square feet.
Total	773	117,530	168	10,880 square feet.

Mr. FITZPATRICK. We are not only utilizing this hospital to a maximum extent; we utilize every other hospital on Staten Island that is available for training. And we are now farming out literally parts of our program to the veterans hospital in Brooklyn and to about four other Brooklyn hospitals.

Thank you, gentlemen.

Dr. KIRSCHNER. I appeared earlier this year at a hearing with reference to our program with the U.S. Public Health Service Hospital. Also, Deal Edith Schmitt from our school of nursing, and Dr. Closey, our director of hospital administration, appeared also.

I wish to emphasize that we have had this affiliation with the Public Health Service Hospital at least in my field since 1934. And we have sent out into the careers in the health professions many health workers and we would like to continue to do so.

Thank you.

Mr. ROGERS. Could you tell us about how many, or you may not have these figures, but maybe you could furnish them, or perhaps it is in your testimony how many are trained here each year?

Dr. KIRSCHNER. Our junior and senior students in nursing affiliate with this institution. I don't exactly have the figures but they are in the record. Our students in this nursing program is a baccalaureate program leading to the B.S. degree and professional nurse program.

The students in hospital administration is a graduate program leading to the M.S. degree.

We affiliate with several institutions, the numbers, again, are—these candidates, again, are in the record. This is an internship period of 1 year's length.

Our students in medical technology vary anywhere, I would say, from approximately up to eight a year. While this quantity may not be large, the facilities of the institution, of any institution are limited by the bed capacity and staff on duty. The facilities such as these in this area are very limited.

A student must work or train in the laboratory for a period of 12 months in order to be certified by special organizations and to be licensed in this career when they finish. The number of students that can be accommodated in the area in all institutions restricts the limit we can send into the field.

Our greatest benefit from this program is that in this area these students who are trained here come back to our graduate level programs and enter our teacher preparation program for the 2-year and community college programs in health careers. So that while we may have direct affiliation for eight students, those eight in turn are responsible for training and educating 80 or 100 more health workers for the health professions.

Mr. ROGERS. Thank you very much. It's very significant.

Let me ask you, Dr. Schueler, suppose HEW said, "We will turn this over to your institution to run." Could your institution possess the financial capability of running this hospital? [Laughter.]

Dr. SCHUELER. Even though that's a policy statement, I would say I don't know. [Laughter.]

Mr. ROGERS. Would your institution be capable of doing so?

Dr. KIRSCHNER. We have been discussing this subject and find it very interesting. And indeed there is a need for such a facility, but, once again, I am not able to make any particular statement. But money, I am sure, is the problem.

Mr. ROGERS. Would your institution have the money to run this?

Dr. KIRSCHNER. I couldn't say so. Dr. Leeseberg, the dean—the associate dean of the college is here, if you wish to ask him.

Mr. CHAIRMAN. Well, I think that's fine. Thank you so much.

Mr. MURPHY. Dr. Bloomberg, Miraldi, and Dr. Leeseberg.

Mr. ROGERS. Welcome. Would you identify yourselves?

STATEMENTS OF DR. DONALD BLOOMBERG, PRESIDENT, RICHMOND COUNTY HEALTH PLANNING COUNCIL, STATEN ISLAND, N.Y.; DR. NORBERT LEESEBERG, ASSOCIATE DEAN, WAGNER COLLEGE, STATEN ISLAND, N.Y.; AND DR. DOMINICK MIRALDI, PHYSICIAN, STATEN ISLAND, N.Y.

Dr. BLOOMBERG. Dr. Donald Bloomberg. I am the president of the Richmond County Health Planning Council and also the administrator of one of the hospitals on Staten Island; Doctors Hospital.

Dr. LEESEBERG. Nortbert Leeseberg, acting associate dean of Wagner College.

Dr. MIRALDI. I am Dr. Miraldi, a practicing physician in the community; I have practiced in this community for 23 years. I interned locally. I am chairman of the health and hospital committee of the community board. I founded and am chairman of the health committee group devoted to improving the health of our community.

Dr. BLOOMBERG. On behalf of the Richmond County Health Planning Council I would certainly like to endorse the keeping open of the U.S. Public Health Service hospital.

Much of what we believe is on the record from the meeting that Dr. Featherstone held at the hospital, so I will not repeat it.

I would, however, like to reiterate from firsthand observation, having come from my own hospital early this morning, and what many speakers have said. There are no beds in any of the voluntary or proprietary hospitals this morning on Staten Island. We literally had to send patients over to the Public Health Service hospital because of this

acute bed shortage. On top of it, my licensed capacity is 146 patients. This morning when I left it was 153.

I have the Department of Health Institutional Review of the city of New York down my neck every week because we have to go over bed capacity. I will take that chance because I felt we have to give health care to the people of Staten Island.

The most important thing that I would like to bring out at this hearing is the unique position of all of the hospitals of Staten Island. We meet together, we share our facilities. In this way we are able to prevent duplication of expensive facilities. There is no need to have cobalt units in every single hospital on Staten Island.

We are fortunate that St. Vincent's Medical Center in Richmond has one. The U.S. Public Health Service hospital has one. Therefore, we feel we are able to send our patients to these facilities and have them treated very, very well.

The excellent consultants that come out of the U.S. Public Health Service hospital to visit patients at our hospital have done a superb job and have assisted the medical staff of the Richmond Borough in giving excellent medical care to their patients.

The hospital has always been willing and able to assist them with us when we have needed beds, equipment, and so forth. It is a unique position.

I strongly urge you on behalf of everyone in Richmond to keep the hospital and expand it.

Mr. ROGERS. As I understand you are president of the Health Planning Council?

Dr. BLOOMBERG. Yes. This is the hospital's health planning agencies, the community groups of Staten Island.

Mr. ROGERS. When you gave information to the HEW team that came out, was it the concensus of the Health Planning Council that this remain in the control of the U.S. Public Health Service?

Dr. BLOOMBERG. Yes, it was, because it was felt that at this point there is no city or State agency that could possibly take it over.

Mr. ROGERS. There is no one available here who could take it over?

Dr. BLOOMBERG. No one here. And honestly, I believe no money available. We are strapped as it is now. Staten Island gets very little from the city of New York.

Mr. ROGERS. Do you have insurance on your hospital?

Dr. BLOOMBERG. We do, sir.

Mr. ROGERS. There is no insurance on this hospital, you know, because it's a Federal installation. Government staffed. What do you suppose insurance would cost for this hospital? Just a guess.

Dr. BLOOMBERG. I would guess it would cost anywhere upwards of $75,000 to $100,000.

Mr. ROGERS. $100,000 to $150,000?

Dr. BLOOMBERG. For the size.

Mr. ROGERS. Which is an added item that people overlook if it is turned over to the community or other sources.

Dr. BLOOMBERG. That's correct, sir.

Mr. ROGERS. Thank you.

Dr. LEESEBERG. May I express my appreciation to the committee for the opportunity of this hearing. I have turned over written statements

to Congressman Murphy from Wagner College and also from the Rotary Club of Staten Island, and would request that they be made part of the record.

(The statements referred to follow:)

STATEMENT ISLAND ROTARY CLUB STATEMENT

The Rotary Club of Staten Island urges Congress to use her powers to keep USPHS hospital open in Staten Island; to expand its program both medically and educationally for the benefit of the residents of New York City and the East Coast.

NORBERT H. LEESEBERG, *Secretary.*

WAGNER COLLEGE STATEMENT

Wagner College has co-operated with USPHS for many years in the training of nursing students. This program is vital to health care and the benefit of all citizens. Congress is urged to do all within her power to maintain and improve the medical and educational programs of USPHS hospital in Staten Island.

NORBERT H. LEESEBERG,
Acting Associate Dean.

Mr. ROGERS. Thank you, Dr. Leeseberg.

Dr. MIRALDI. Gentlemen, during the past 10 years it became apparent to me as a practicing physician that there was developing a critical hospital shortage on Staten Island.

In 1968 it was so critical that I as a doctor took time out to address myself to the problem. With a committee which I had formed, which I have listed before, I developed a concept that the only instant and feasible solution to the situation on Staten Island would be the establishment of a municipal hospital.

I therefore embarked on a campaign in which I ran an ad, newspaper articles, wrote letters, and influenced thousands of our citizens to write letters to all officials at the three levels of government, the Federal Government, State level and local level.

Now, the situation on the island is so serious I frankly can say, as a practicing physician, if anyone became ill at this moment, seriously ill, I could not get him in an institution outside this hospital. This hospital is the only backup. And if this hospital is closed it is really a method of killing off our citizens.

Last month I had a meeting with the State health officials to explore the concept of a municipal hospital. I reviewed the shocking statistics. At the present time there are 893 beds on Staten Island. 194 of these beds are nonconforming beds, that is, beds that do not meet modern standards and are not acceptable, which leave a total of 699 beds for a population of 295,000.

The officials at the State Health Department conference who conferred with me stated that the need for beds until 1974 is 1,140 beds. So that we are short 441 beds.

I would also like to review the different hospitals and their capacities. As Mr. Bloomberg said, Doctors Hospital has 146 beds; they are conforming beds. I think we ought to give him a hand for that. [Applause.]

As I understand, they have no plans for expansion.

St. Vincent's Hospital has 310 beds, 290 of these are nonconforming beds. This institution plans to erect and finance a medical care facility of 300 beds. They have the idea that extended care facilities can take

care of less critical patients and patients convalescing. But medicare decisions to date speak against the use of this facility for this purpose so that we cannot look at this institution for any relief in our shortage of hospital beds.

They also plan to erect a 100-bed mental health facility. At the present time they are running 30 beds, which they have leased from a nursing home on Staten Island.

So, this brings in the concept of leasing beds in another institution. I historically initiated that concept. My idea of a municipal hospital came later on.

Staten Island Hospital is using 276 beds. Of these, only 118 are conforming beds. They plan to relocate at the South Beach Psychiatric Center, which is a State mental institution, which will take patients from all over the State; they plan to erect a 500-bed facility. They will have to give medical support to these mental cases. This will decrease the number of beds for our community quite a bit.

Even if this plan were started today, it would take 5 to 7 years to complete. At the present time it hasn't even gotten off the ground.

Richmond Memorial Hospital now has 174 beds. They plan to expand by the mid-1980's to a capacity of 434 beds in three phases.

In the first phase, which is now going on, they are building a structure of a basement, subbasement, and two floors which will house supportive facilities of the hospital and 63 beds will be added.

Phase 2 will add three more floors or 109 beds, and phase 3, which will occur in the 1980's, will give 126 beds by adding two floors.

Let me look at this hospital a minute. This hospital has 636 beds. The last time I contacted the administrator they ran a census of 493 beds. The administrator told me they would increase personnel and they could have 70 beds made available to the community. However, other sources point out this hospital runs at a capacity of 66 percent, so that 150 beds would be available for community use.

Also, it has been pointed out that approximately 25 percent of the patients here come from Staten Island. That gives us about 100 patients, so that if you close the institution today, the local hospitals could not absorb these 100 patients.

To meet this situation in 1968 I developed the concept of establishing a Staten Island Hospital Authority. I drafted a bill in that manner. This authority was to create a municipal hospital in two phases.

In the first or acute phase the hospital was to lease the beds of this institution for use by the community. The prolonged phase—in the prolonged phase the hospital would erect an institution preferably in the center of the Island, or in the event, and God forbid that should happen, this institution is closed, that the authority would take this institution and run it as a municipal hospital.

Now, the question of funds came up. Where do we get the money? The State has a health mental hygiene improvement corporation which will come into a community and build a hospital and lease it to the community.

As an authority we would also have the source of funds from bonds and capital expenses, as you gentlemen know.

In my conferences with the State health officials they have suggested that we explore the possibility of having this authority as a

subauthority of the Health and Hospital Corporation of New York City.

I urge that this institution be kept open and used by the community in the manner that I have proposed.

Thank you.

Mr. ROGERS. Thank you very much.

If it were used and run as a community hospital, could merchant seamen be assured priority treatment?

Dr. MIRALDI. I think that could be included in the bylaws or in the bill.

Mr. ROGERS. Or other citizens, taxpayers?

Dr. MIRALDI. You could apportion a certain part of so many beds for that purpose.

Mr. ROGERS. I question that myself. You may be correct, however. This is one of the problems in the turning over of a hospital to the taxpayers, where you have a group that is a beneficiary by law.

For instance, the VA could not give priority to merchant seaman over the VA beneficiaries, you see.

Mr. BLOOMBERG. It would be interesting to note that at the meeting that was held in March it was pointed out that to bring this hospital here into conformity with the health and hospital code of the city and State of New York would cost anywhere from $26 to $30 million.

Mr. ROGERS. Would your group be able to do that?

Dr. MIRALDI. No. Well, this would be a hospital authority; it would have a source of funds from the State and also a source of funds from the issuing of bonds and help from the city.

Mr. ROGERS. Has this passed; is this a fact already?

Dr. MIRALDI. No; we are proposing some more meetings with city officials to explore the concept.

Mr. ROGERS. I see. It is not a reality; this is something you are thinking about.

Dr. MIRALDI. Yes; a lot of thought has been given as to how the community should use this hospital but no one says how. This is our problem.

Mr. ROGERS. Fine. I understand.

We are hopeful that we can keep it open as a Public Health hospital. I presume you would prefer that first?

Dr. MIRALDI. Yes; in that event this authority could lease extra beds for use by the community.

Mr. ROGERS. I don't think that's necessary under the authority already given the Public Health Service to serve the community.

Dr. MIRALDI. In other words, in making up this concept I looked around and said, where are we going to get these beds? Here is the only place we do have beds available and it doesn't appear to me to be right to have these beds lying around and people that need these beds not getting the care.

Mr. ROGERS. I understand now you are adding emergency patients from the community to this hospital?

Mr. BLOOMBERG. That's correct. But one of the problems that arises is that when a patient is admitted to a Public Health Service hospital his prior attending physician no longer has any control over him and is literally off the case. This has caused some problems.

Mr. ROGERS. I understand that.

Thank you so much.

Mr. MURPHY. Mr. Gleason and Mr. Russo?

Mr. ROGERS. Would you please identify yourself?

STATEMENT OF JOSEPH GLEASON, NATIONAL VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, STATEN ISLAND, N.Y.; ACCOMPANIED BY PETER RUSSO, PRESIDENT, LOCAL 888

Mr. GLEASON. I am Joseph Gleason, national vice president of the American Federation of Government Employees.

Mr. RUSSO. Peter Russo, president of local 888 of the American Federation of Government Employees.

Chairman ROGERS. Welcome to you, Mr. Gleason, and Mr. Russo. It is good to see you again. I think your statement can be made a part of the record here.

Is this your prepared statement?

Mr. GLEASON. Yes.

Mr. ROGERS. Your national chairman presented it yesterday as you know, to the committee in Washington.[1] You may make any additional statement you want for the record now.

Mr. GLEASON. On behalf of our local 888 here, at the outset I would like to express our deep appreciation for the understanding and compassion of Congressman Murphy, particularly in bringing this committee to this site.

I frankly believe, as the previous speaker said, it is far better, as they say these days, to come and rap with the people in the area. I think you get a better picture of it.

I would like to extract just three areas of the statement. Mr. Griner presented yesterday. Two of these areas were dealt with by the Featherstone Task Force and at the hospital.

I would also like to refer to the heart-rending speech presented by the sister and her brother earlier.

On that basis, Mr. Chairman, I would refer you to page 4 of the testimony because, indeed, what the sister had to say I think is borne out by the statement and is the only one in the entire 11-page statement that is underlined. And it was our feeling that we could envisage these people going from hospital to hospital, traveling long distances in pain, simply because their Government was so busy dreaming about a good and universal health program for the future that it decided to ignore the present.

I think, certainly, the sister made that point quite explicitly, as did some of the community representatives.

I am one who believes that aside from the fact in defending the hospital and clinics, in keeping them open, it seems to me we all have a greater responsibility. And I respectfully suggest perhaps the time for defense is over and the time for attack should begin.

We said in our testimony yesterday that we were very surprised that this and past administrations have allowed a situation to develop where the hospitals have become rundown as they are today. I would like to explain that term "run down" as it appears in our testimony.

[1] See statement of John F. Griner, national president, American Federation of Government Employees, p. 356, this hearing.

Before the Featherstone Task Force we made the point that we had read in great detail the testimony of Secretary Richardson before the congressional committee. That testimony is replete with terms like "underutilization, inefficiency, et cetera, et cetera."

Perhaps I might have oversimplified things when I tried to draw a comparison with what happened with the Ford Motor Co. many years ago when they put out an automobile called Edsel. The car turned out to be a bomb.

The fact of the matter is that Ford didn't close its plants, it didn't discharge all of its people. I think very simply I am trying to say the same thing here.

All the testimony that has been given from the time that this first began shows that we have a highly trained professional group of people who have done an outstanding job.

I have suggested to the Featherstone committee that they might go back to Secretary Richardson and tell him to take a look inward at some of the management practices that have allowed the so-called run-down condition to exist.

Our testimony, as you recall, Mr. Chairman, yesterday said that we have recalled that when the basic subject of these hospitals was last before Congress in 1965, the Deputy Assistant Secretary of the HEW, Mr. James Kelly at that time gave assurances that appropriations would be found to improve hospital facilities providing for overall modernization and expansion.

Yet, despite congressional commitments to improve the facilities, the executive branch, and this is not only this present administration, but past ones, have ignored this mandate to carry out the necessary improvements and now once again come up with proposals to destroy the vital Federal function.

I think again, Mr. Chairman, what I am saying is that there is certainly enough testimony in the past, there is enough concerning that, I respectfully suggest, that this committee follow through the proposal we made to the Featherstone group and, indeed, let's find out what top management has been doing. I think that's really where the problem lies.

The other point we made to the Featherstone committee is that we have a great deal of concern about what is the obligation of the Federal Government as an employer and we asked at that time what the Government's plans were, what did they intend to do with the employees here? Did they have any proposal in mind at all? Unfortunately, I think that has been answered for us and we are very concerned about it because, as I recall, Mr. Chairman, yesterday Mr. Griner stated that the 1971 budget of the Department of Health, Education, and Welfare for public service shows a drop from 6,242 in 1971 to 970 employees projected in 1972, or a decline of 5,270 people.

It would seem to me that the intent of the Department is quite clear in making those projections.

That, in summary, is our statement and we thank you for the opportunity to appear.

Mr. ROGERS. Thank you.

Would you like to speak?

Mr. RUSSO. No, he said it all.

Mr. ROGERS. We share your concern. That's why we are holding these hearings. I think we have had preliminary assurance now that the Department is rethinking. We have had a considerable pressure from the committee and they have made these statements and they will keep this hospital open unless and until something could be worked out some way to continue this appropriation or turn them over to the community.

I hope we are getting them now to rethink that, and I agree with you that it is the intent of Congress that we not decrease Public Health Service but increase it.

The last legislative act that we passed in this past Congress was to increase the role of the Public Health Service. And we are going to try to pursue that very diligently in this committee. I think the Congress will support this committee in that activity and endeavor.

What we have here basically I think is another bureau of the budget. Now they call it Office of Management and Budget. It's the old Bureau of the Budget, saying well, we are just going to cut out so much money. I don't think the Director of the Bureau of the Budget nor the Secretary are fully briefed on the extent of the services as to what the Public Health Service is doing. We are going to educate them. [Applause.]

Mr. GLEASON. Mr. Chairman, my closing comment would be that it is a tragedy that they couldn't find their way to be here today.

Mr. ROGERS. Yes. Thank you so much for your help.

Mr. MURPHY. Mr. Fortoloczki and Mr. Walsh, administrators of Staten Island Hospital and St. Vincent's Hospital.

STATEMENTS OF KALMAN J. FORTOLOCZKI, ASSISTANT ADMINISTRATOR FOR PLANNING AND DEVELOPMENT, STATEN ISLAND HOSPITAL, STATEN ISLAND, N.Y., AND JOHN R. WALSH, EXECUTIVE VICE PRESIDENT, ST. VINCENT'S MEDICAL CENTER, RICHMOND, N.Y.

Mr. FORTOLOCZKI. I come here as a representative of the hospital but I am not prepared to make a statement.

Mr. ROGERS. It is perfectly all right. We are delighted to see you here.

Mr. WALSH. I didn't come here to make a statement, however, there are a few things I would like to say, and that is that I agree it would be a great tragedy if this institution were to be closed and these beds denied the residents of Staten Island.

These beds are urgently needed and as a matter of fact, we represent a 342-bed institution which is running in excess of 100 percent capacity in both medical and surgical areas and we have a waiting list of approximately 135 patients.

It sometimes takes a month or greater than that before an elective case can get into our institution. And we have been able, in case of emergency, to transfer some of the patients over to the Public Health Service hospital.

Do I gather that the decision has already been made to keep this institution open or is it still——

Mr. ROGERS. The Assistant Secretary of Health, Education, and Welfare, Dr. Egeberg, and the Comptroller for HEW, appeared before our committee. And we pressed them as to what action was going to be taken now. We can't wait until July and find out. We want to know now. They told us that they would give assurance that the supplemental budget request would be made to keep these hospitals open until they could decide what they wanted to try to do.

So, I think we have their assurance that these are not going to be closed as had been first indicated by the budget figures.

I think we made that much progress but that's only a beginning as far as this committee is concerned.

Mr. WALSH. In the event this hospital decision should come up, the question should arise as to its closing, I think we would like very careful consideration being given to perhaps turning it over to our institution where we are limited in what we can do in our present institution.

There are no excess available Government funds that we can attach nor to expand our institution.

One of the possibilities would be to transfer over here. It is true it would cost somewhere between $30 to $40 million to bring this institution up to code. But I would point out this is about 2 years' deficit the way the institution is now running, as I understand it. And in 2 years' time it would eliminate the deficit for the years to come.

The institution could be a valuable institution from a financial standpoint.

Mr. ROGERS. How do you mean there is a deficit here?

Mr. WALSH. As I understand it, the budget for the institution is somewhere in the neighborhood of about $20 million a year.

Mr. ROGERS. I don't think there is any deficit there. These are funds we provide for services for beneficiaries that are legally entitled to them. There is no deficit.

Mr. WALSH. Perhaps if it were turned over to a voluntary hospital and was subject to the usual financing, this amount of money would not have to come out of the Federal budget.

Mr. ROGERS. I am not sure that I agree with you.

Let me ask you, what does it cost per patient to stay in your hospital?

Mr. WALSH. About $100.

Mr. ROGERS. Do you know what the cost here is?

Mr. WALSH. I presume somewhere in the same neighborhood.

Mr. ROGERS. No, I think not. It's about $60, $63. That includes physicians' services. So, from the facts we have gathered to turn it over to a nonprofit or private institution would about double the costs for the Government to get similar services. It is not going to save you very much money.

Mr. WALSH. The dollars would come out from other pockets rather than the Federal Government, I think.

Mr. ROGERS. A $40 million modernization, is that going to come out of private pockets?

Mr. WALSH. Of course, that would be a one-time cost.

Mr. ROGERS. But that is a rather considerable cost.

Mr. WALSH. But thereafter the Federal Government would not have to come up with——

Mr. ROGERS. What about insurance, $150,000?

Mr. WALSH. That, of course, would have to be included as part of the cost.

Mr. ROGERS. There are many costs. I think without question all of the experts we have heard from say, without question, it would almost be double the cost to the Government to turn it over to a private nonprofit association.

You are talking about getting medicare payments to help pay for it. Well, there is no reason why they couldn't do that here extra beds.

What are you going to do with the merchant seamen? Would they get priority treatment in a nonprivate hospital?

Mr. WALSH. They don't today.

Mr. ROGERS. They do here.

Mr. WALSH. I realize that.

Mr. ROGERS. By law they must. These are problems that the committee has to deal with, but we do appreciate your testimony and it is helpful. We are grateful for your being here.

Mr. WALSH. I think it should be remembered I did not come here prepared to render a statement.

Mr. ROGERS. We are grateful to you for your presence and for your remarks.

Mr. MURPHY. I ask at this time that any members of the hospital staff that are here listening to the testimony and who would like to make a statement to please come up to the witness stand.

Mr. ROGERS. I might say if anyone on the staff would like to make a statement, you can be assured you have the full protection of this committee. If I hear of anyone taking any adverse action, we will see that they are prosecuted criminally.

STATEMENT OF EUGENE F. PERCOCO, LICENSED PRACTICAL NURSE, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Mr. PERCOCO. May I be allowed?

Mr. ROGERS. Certainly you may. Please identify yourself.

Mr. PERCOCO. Eugene F. Percoco, I am a licensed practical nurse employed at this installation. I have been here approximately 5 or 6 years.

I didn't come as a result of an invitation. I came as a result of some incident that happened only today and I would like to say that I have requested annual leave to be here present as a spectator and have not been able to say anything. But I have quite a bit of information and——

Mr. ROGERS. Would you like to submit it for the record?

Mr. PERCOCO. No, I have to go over it myself because unless it is administratively correct, I might be reprimanded, sir.

I have an annual leave slip here in my pocket which I had to request to get to see you and no one knows that the hearing in effect took place today. I just happened to find out that it was in the conference room in the basement.

Since I am always being reprimanded, quote unquote, my personnel folder and other records at this hospital would substantiate I have had to, in order to protect my job, secure an application for leave, a special request form in duplicate at my request from the director of nurses.

Mr. ROGERS. Let me say this. I would hope that the director will straighten that out after the hearings.

Mr. PERCOCO. I should hope so.

Mr. ROGERS. Now, what is it you would like to say?

Mr. PERCOCO. I don't see any representative from any licensed practical nurse organizations here, or VA, or allied medical or paramedical with respect to the licensed practical registered, State approved, with all the paraphernalia that's required in order to be employed here, represented here.

Since I was not told or was not informed of this committee, other than through this paper that I just happened to find on a chair conveniently. I am here, to quote someone, by the grace of God.

Mr. ROGERS. What would you like to tell us?

Mr. PERCOCO. I would like to know who asked a question.

Mr. ROGERS. Let's proceed with the testimony.

Mr. PERCOCO. I will. I would like to say why wasn't the hospital personnel informed so then in effect I could be here in behalf of a person that works here as a licensed person and then discuss some of the problems.

Mr. ROGERS. May I say this——

Mr. PERCOCO. And testify with regard to this hospital.

Mr. ROGERS. This is why the committee is here. I understood it was in the paper that it would be here, but I don't know why they didn't put it in the form of a notice.

Mr. PERCOCO. I happened to find out when my daughter was brought to the emergency room, sir.

Mr. ROGERS. Let me say this, if any staff person or anyone else desires to submit any statement to this committee, they may send it to us. We are not closing the hearings. We will go over it carefully and make it a part of the record. So that if you are not prepared to file a statement, you may present it as you want and we will give you the address of the committee and you may send it. We will go over it and make it a part of the record.

Mr. PERCOCO. Thank you.

And I failed to say excuse me to all the distinguished members and the audience for interrupting, since I didn't sign it.

Mr. ROGERS. We are delighted to have you here and present.

Mr. PERCOCO. Thank you.

Mr. KYROS. I have one question: Are you in favor of having the hospital remain open?

Mr. PERCOCO. Am I in favor of keeping the hospital open? Yes, since I am incumbent to save people's lives and I have been trained, I am in favor of having the hospital open.

Chairman ROGERS. Anyone else? Identify yourself, please.

STATEMENT OF DR. STANFORD LEFF, STAFF PHYSICIAN, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. LEFF. My name is Stanford Leff. I am a physician on the staff here. I act as a medical resident in internal medicine.

I am not quite sure what the limitations are on me in terms of being able——

Mr. ROGERS. There are no limitations on your speaking before this committee. If there is any reaction to this, if you will notify the committee, we will take the necessary action.

Dr. LEFF. Thank you.

I have to admit when I found out that the administration was considering closing the hospital, I wasn't too surprised.

I have been in the Public Health Service system for about 3 years. During that time I have come to realize the hospitals weren't really that busy, that they are always having a lot of empty beds. And this has never been true in any other hospital that I have worked in. I always felt the hospital was unused to a degree and I usually blamed the eligibility requirements for this.

I knew there were many people in the community who couldn't get beds in a hospital and who would probably use a bed if they became available in these hospitals.

So, for those reasons I wasn't too surprised when I heard about the plans, but of course, I was horrified because it is clearly terrible to close hospitals in a community that is hungry for hospital beds, where clearly every hospital is filled. This is probably true across the country. Instead of someone saying we should be opening hospitals instead of closing them.

So, I am pleased that the issue is being reconsidered.

The thing that bothers me, though, is how are we reconsidering it? If we say we are going to keep the hospital open and expand the hospital, what kind of an expansion is it going to be? There seem to be several arguments for keeping the hospitals open. One is for research and the teaching programs that they provide.

To me, it was somewhat ironic that such a large portion of the testimony by our hospital officials here today were spent discussing the research, the renal unit, and the cardiovascular unit, perhaps the only two units in this hospital which could be called, or at least the only two units that appear to be well-founded and well-staffed and well-supplied.

To me, the question isn't whether we should make Dr. D'Amato's electrocardiac lab more superior. The question is are we going to provide health care for the needy community, going to change the hospital and open it up to the community?

Similarly with the teaching, it's very important but the immediate need that should be arresting everyone's attention is the need for beds and health care.

Then, the testimony comes from private physicians and administrators of private hospitals who see this hospital as a much-needed source of overflow beds. They will try to get their patients into their private hospital every time. If they find there is no room, then they will send them here and lose control of their patient and allow us to treat them.

I agree these patients are important and we welcome them and take the best care of them we can. But it isn't for that reason that this hospital should be kept open.

People who really need the health care and need the hospital and really need a change in this hospital are the people in the medically deprived community, the ghetto people.

I was a little bit upset that we haven't spent more time discussing plans in these areas, discussing creating a strong commitment to providing health care for the ghettos, a strong commitment for training which should include active community input, and geriatric programs, and drug abuse programs, and community training programs.

Mr. ROGERS. I think the committee gets the gist of your testimony.

Dr. LEFF. I also suggest if you are considering some long-term, on-going program for providing health care to the community, it may be that the 2-year physicians who are young and early in their careers and working there by and large only to fulfill their military obligation, may not be the best possible sources of doctors to provide legitimate health care for the community. And it would be a tragedy if any on-going health care programs on this type of treatment were based on such a premise.

We should try to get indigenous local community to provide the health care for the people.

Mr. ROGERS. Ideally, that is true, and we would all like to do that. But there are areas where you can't get indigenous people, medical people. You just can't find them. They have moved out or they are not there. That's why we passed this bill, we expanded the public health commitment to do the very thing that I think you are talking about.

We have laid the foundation for you doctors to do that, to treat our core area, ghetto area, the communities where they don't have sufficient medical personnel. That's the expansion Congress has envisioned and which it did over the objection of HEW, I admit.

We just passed that bill. It is not yet implemented, but we have assurance they are asking for $10 million in the supplemental budget to begin to do that. This, therefore, can put the Public Health system and these hospitals in a position of helping those who need medical care.

Dr. LEFF. I hope we all see that as a temporary stopgap until these communities are revitalized. And I would suggest that it might be a good idea to begin to include non-PHS elements in the running of the hospital. So that when the time comes that the administration of the hospital can be turned over to the community that it is possible and perhaps facilitated by this cooperative effort.

Mr. ROGERS. I don't see the turning over to the community of the Public Health or the VA hospital, in my own mind. I think we need an in-house capability to do innovative work, to begin to develop new careers.

So, I think it is commendable to want to develop, as you say, the community physicians but what we are trying to do is supply the need where we can get physicians. This is the most critical fault.

They can go out and build a hospital. This is to serve basically the beneficiaries of the Federal Government. This is the foundation of the hospital.

We also service secondary beneficiaries as well as prime. Now we have added another core area which is the ghetto area where you have—or the community where they have no health care.

So, we have tried to broaden this in line with your thinking.

STATEMENT OF DR. MICHAEL WEDER, STAFF PHYSICIAN, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. WEDER. Michael Weder, a physician, resident in pathology.

I have no suggestions or statement regarding the disposition of the hospital, private or public, and so forth.

I would just like to further bring my own thoughts to the committee regarding the element of risk, and I know that has been hashed over. You guarantee the protection of the Congress to any physicians or staff people who might wish to make a statement.

I'd like to ask, first of all, for I know there are other people that would like to make a statement, what type of risk are we under if someone should make a provocative, radical statement?

Mr. ROGERS. Why don't you do this——

Dr. WEDER. Make a statement and try? I don't know. [Laughter.]

Mr. ROGERS. No, I am not going to ask you to do that. What I do say is if anyone intimidates you because of any statement made, we will see they are prosecuted under the criminal laws of the United States, and that action would be directed in your instance.

Dr. WEDER. But the types of incrimination are subtle, a transfer, a recommendation which you might or might not deserve.

Mr. ROGERS. If you feel it was the result of that, this committee would take steps.

Dr. WEDER. You go back to Washington and we stay here.

Mr. ROGERS. Well, we are pretty close, you may telephone. Congressman Murphy is here on the job. If you prefer, why don't you just write us what you feel and we will not make it part of the record if you don't wish to, but we will know and I will see that each member of the committee reads it. Then that wouldn't jeopardize your position.

Dr. WEDER. I am not saying this because I have a specific suggestion, it's just attitudinal.

Mr. ROGERS. Anyone who wants to do that, if you will write to me or any member of this committee, we will see that other members read it and it will not be part of the record. No one will know.

Dr. WEDER. Anything I say I prefer it be known. I don't want it unknown.

Mr. ROGERS. I am trying to accommodate you.

Dr. WEDER. Thank you.

Mr. ROGERS. Does anyone else have a statement?

STATEMENT OF DR. JACK GUGGINO, STAFF PHYSICIAN AND PRESIDENT, COMMISSIONED OFFICERS ASSOCIATION (U.S.P.H.S.H., CLIFTON, STATEN ISLAND, N.Y.)

Dr. GUGGINO. Dr. Jack Guggino, resident, ophthalmology, president, Commissioned Officers Association.

Mr. Chairman, president, members of the subcommittee:

I represent the commissioned officers and I would like at this time to make a statement and a plea.

Many of us are dependent upon the institution for valuable training which, as Dr. Roy knows, is very short anyway. I feel I reflect

the feelings of most of our commissioned officers in saying this hospital should be better funded and better staffed.

With all due respect to our advice on policy matters, I believe it is our duty to interject policy during this critical time even at the expense of conflict of interest.

I understand the problems of my fellow commissioned officers. This instability and insecurity is damaging to our morale and our training program. HEW is toying with our careers. It is commonsense that the basic framework be expanded and set up as a strong leader of the medical care training and research in our community and in our State.

My plea is one of making a direct decision as possible so that medical trainees and career officers have an opportunity to act accordingly.

Mr. ROGERS. Thank you, and you have made the point this committee is trying to make. That is that we must have a decision because young men and women must decide on their careers and you can't wait until July if there are no budget funds and then find out the hospital is going to close. You have to know. We are going to press for this decision and I think we can.

I can give you this assurance: I believe that the Congress will stand behind this committee in keeping open our Public Health Hospitals and in expanding the Public Health Service [applause].

Dr. GUGGINO. Thank you for this opportunity.

Mr. SYMINGTON. I have no questions, but I do think that we should be careful in our society and in our institutions not to issue directives to people who are trying to function within these institutions not to discuss the policy. There is more to the first amendment than the letter. There is the spirit of it. People ought not to be inhibited from saying what they think about how any part of the country is being run. Most Americans, I think, will be difficult to control in this way. But if they are to be asked to refrain from exercising their options on policy issues which affect them, I think it's asking too much of them.

I would hope that the authorities of the Department in question would see fit not to issue such directives in the future, and to indicate to the gentlemen who made the phone call that it was a mistake.

Mr. ROGERS. I share the feeling, and we shall take this up very strongly with the Secretary of HEW to see this is not the departmental policy.

STATEMENT OF MARTHA KENEEN, NURSING ASSISTANT, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Miss KENEEN. My name is Martha Keneen; I am a nursing assistant.

I would like to say that the way the hearings were in January and these hearings, the employees of the hospital were not notified, were not asked to come. It is as if the fate of this hospital has nothing to do with them.

By our seeing a statement yesterday in the afternoon saying there is going to be a hearing, is not fair to the employees.

The employees are harassed and intimidated, and they are not going to speak up. You can come down and say we are going to give you protection; it doesn't mean a thing to them. The thing is that you have a publication and you have a hearing, give people time to prepare, to

tell what's really going on in this hospital. And there has to be some form of protection other than your saying protection will be given because people will be intimidated, harassed, suspended, fired. And it has been going on and on.

We must do something now, and we must be considered in making the decision, not the hospital. We have to be allowed to tell our views, not only by writing a letter to you but by being able to have an open hearing.

Mr. ROGERS. Of course, we are trying to do this. I am sorry we didn't get more notice to you. The committee has a very heavy schedule, as well as you do, I am sure you realize. All of these members have tried to come up here so we do have some discussion.

We have also had private discussions with members of the staff as we have gone around, which are not a public record.

We may have to ask you to let us have your views in writing for those who feel they have not had an opportunity to be heard fully. We will either keep them confidential or make them part of the record, according to whatever the individual desires and indicates and lets us know.

I am sure, too, that Congressman Murphy, who is here, often will be very glad to have anybody come and discuss it with him. And he can certainly transmit the views and feelings, so that I want you to feel that there is an open avenue within this committee, and with the Congress through your own Congressman, directly to the committee.

And, as I say, I am sorry we could not give more notice, but this is the only way we could handle it, to get up here in time to try to be effective against the closing of the hospital.

Miss KENEEN. I would also like to say that as far as Dr. Leff here says, the hospital is underutilized and understaffed, and also that the hospital should be providing better services than it is, and should have more of a community-oriented hospital approach that would best serve the community.

There are enough beds in the hospital that aren't being used to make it a community hospital and to set the priorities for the community people because the people in the community are starving for the hospital and for beds.

We should have the modern approach to medicine, not some barbaric, in the 1800's aproach. There should be a modern approach to addiction, geriatrics, day care centers, women's problems.

There is nothing on this island or this city or the whole country that is hitting the main focus on these problems. We should do something about them.

Mr. ROGERS. Thank you. I share your feeling, and I do believe we have established the basics in law now for us to do some of the things that have not been done before in a Public Health Hospital.

Mr. MURPHY. Reverend Epps and Reverend Armistead.

Mr. ROGERS. Identify yourself; and if you have statements, they will be made a part of the record at this point; and summarize for us, if you like.

STATEMENT OF REV. WILLIAM A. EPPS, JR., PASTOR, ST. PHILLIPS BAPTIST CHURCH, STATEN ISLAND, N.Y.

Reverend Epps. Rev. William A. Epps, Jr., pastor, St. Phillip's Baptist Church, Staten Island, N.Y.

Mr. Chairman, members of the committee, Congressman Murphy, I speak as a clergyman, and I hope it doesn't sound like a Sunday morning sermon. This is a great hospital, and the great good that it has done is only known to God Almighty.

I have had the opportunity to visit most of the hospitals in our city, and this is one of the best, if not the best. I believe that whatever happens to us, even to you honorable gentlemen, the position where you sit now, I realize that your constituents put you in office, but ultimately God is using you as an instrument of his peace. And you and you alone must give an account to God for the good that you do to those that are less fortunate than we are.

The rumors that this institution will be closed or curtailed has had a very discouraging influence upon many dedicated doctors, nurses, aides, and the entire employed staff here at the U.S. Public Health Hospital.

Even the people in the community are upset with these rumors. That in itself has affected many of the patients.

Gentlemen, in all honesty I would like to ask this question: Is this situation fair? I heard the first speaker relate to you how he gave you a tour, how you looked over some of the facilities of the institution. But I wonder, how many wards did you go into? I wonder how many sick faces did you look at? I wonder how many people did you see that had no hope at all but today they have a beautiful outlook because of this institution, because of the dedication of the dedicated doctors and nurses.

Gentlemen, from the bottom of my heart I speak, I believe, for our community. I want to thank you, and especially my friend, Congressman Murphy, for your deep concern for all of us, especially for the sick who are in great need of care, love and compassion.

We read in the holy writ where it says, the least that you do unto one of these low ones, you do it unto me.

May God bless you and guide you in your deliberation as you think upon the hospital.

Thank you very much for time out of your busy schedules and for coming to do whatever you may do or whatever you can do to help our sick.

Not only is the U.S. Public Health Hospital understaffed but all of the hospitals on the island are understaffed. We need your help badly.

God bless you, and we shall remember you in our prayers. May God bless you and your loved ones.

Thank you. (Applause)

Mr. Rogers. Thank you, Reverend Epps.

STATEMENT OF REV. AUSTIN H. ARMISTEAD, PRESIDENT, STATEN ISLAND DIVISION, COUNCIL OF CHURCHES, STATEN ISLAND, N.Y.

Reverend ARMISTEAD. My name is Rev. Austin H. Armistead and I subscribe to what Reverend Epps has said.

I am president of the Staten Island Division of the Council of Churches and I am pastor of the Faith United Methodist Church and a member of the Community Planning System Committee of the Mayor's Organizational Task Force for Comprehensive Health Planning.

Although I speak as an individual, for purposes of identification, I have prefaced this statement by stating my relationships. However, these groups support the retention of the United States Public Health Hospital.

I think it's unique in that I served at a church in the Bay Ridge section of Brooklyn, which is also another part of the congressional district served by Congressman Murphy. And one of the things felt by both parts of his district was animosity about the building of the bridge because one way or another you are losing homes, things like that.

But one of the advantages that has come, and I think we need to look at this in a little bit broader way, is that with the building of the bridge, the public gained easier accessibility of getting to the other boroughs and particularly Brooklyn. And this is a very important factor. That is, with the exception of the bus traffic hours going in the morning or coming out in the evening.

There are things like fire fighting or health protection that are assured to make it a more viable product than it used to be, and I think we should recognize this.

I have a statement, I am going to take part of it right now. I believe that had HEW and the United States Public Health Service, from Washington down, worked at an earlier time to establish a closer relationship with the community health needs, that people have been bringing up before you, a hearing like this today would not have been necessary.

As pastor of a church here on the island, I am aware of the acute need of more hospital beds and services. Time after time a parishoner will say, "I'll be going into the hospital on Monday." I know more than they do that it may not be that succeeding Monday but it may be many Mondays later, unless it is an acute case.

My observation is that many hospitals are filled with older persons, many of whom had their medical needs cared for and could be placed in nursing homes or other facilities. I don't know whether it's a lack of courage on the part of doctors to discharge a person and having him go to a nursing home or whatever it might be.

But in any event, younger persons are not able to get service excepting for emergency beds.

I have nothing against the older persons. I worked with them down through the years in the New York area in health-related fields. But I wonder about what we are doing for other needs, such as psychiatric facilities, in-patient or out-patient facilities to deal with problems related to drugs, the need for more emergency rooms and clinic facilities,

since doctors are not always available when needed, and when people have no regular family physician.

On an emergency basis I am aware of the wonderful contributions that have been mentioned here today about what this hospital has done to contribute to the specialized needs and to the emergency needs.

But I feel the time has come for the role of the United States Public Health Service, as you have said, to be altered, to recognize, too, that we all have the same interest, to care for patients and prevent diseases.

I recall a report of the Joint Committee of the American Hospital Association and the U.S.P.H.S. entitled "Area-Wide Planning for Hospitals and Related Health Facilities." In part it said, "Through areawide planning local agencies can help to"—lifting out of context but not destroying the meaning—"maintain and improve quality of care as economically as possible. Correct deficiencies in existing facilities and services. Assure more effective use of the community funds by avoiding unnecessary duplication of highly specialized, infrequently used expensive facilities."

For instance, as an example, take the need of some places to take care of burns, we will say. Why in the world should every hospital on Staten Island be set up as a burn unit? Why should every hospital be set up this way when this more carefully planned specialty can be taken care of in a specialized way?

I believe we need to also encourage, as mentioned, the individual facilities to define and carry out their objectives and projected roles in relation to other facilities, service, and community needs. Improved patient care by developing more effective interrelationships among facilities. Develop an orderly distribution of all facilities in keepng wth the projected population characteristics and the overall community development. Stimulate facilities to recongize opportunities for the better coordination of services.

I speak positively on the need to (1) maintain the facility and (2) to relate the facility more closely to the needs of this area of the country. And when I say this area, I am thinking of a little bit broader than just our island, I am thinking of the metropolitan area.

Thank you very much.

Mr. ROGERS. Thank you, Reverend Armistead. I might say we share your concern on an areawide planning, comprehensive planning. This committee wrote that law. We are just beginning to get it implemented in many areas.

Reverend ARMISTEAD. I might say, parenthetically, the way you conducted this has been a pleasure.

Congressman Carl Perkins, whom I appeared before on about three occasions, a similar head of a national committee on the employment of migrant children, treated this kind of thing with the same kind of examination and interest. I think this is reassuring to me as a person and it ought to be reassuring to all staff people in the institution.

Thank you. [Applause.]

Mr. MURPHY. I now call Mr. Leon Burledge from the Marine Engineers Beneficial Association, and Mr. Condiotti, who represents the Staff Officers Association. They have had over 100 men in this program graduate from this institution.

STATEMENT OF MAX CONDIOTTI, ADMINISTRATOR, MARINE ASSISTANTS PROGRAM

Mr. CONDIOTTI. I am the administrator of the marine assistants program.

I know that my wise old mother told me many years ago that the attention span of any congressional committee is always in inverse proportion to the stomach rumblings of that congressional committee.

I myself have had only one cup of coffee this morning at 6 o'clock.

I will make my presentation short. I have brought no prepared statement with me. I merely wish to insert into the record the remarks made at the last commencement exercises of the Marine Physicians Assistants Program by Congressman Murphy, Deputy Surgeon General Dr. Paul Petersen, and Assistant Chairman, Mr. Robert Blackwell.

(The remarks referred to were received for the record as follows:)

[Excerpts from the graduation exercises held on May 28, 1970, of the Pharmacist Mate Training School, U.S. Public Health Service Hospital, Staten Island, N.Y.]

REMARKS OF ROBERT J. BLACKWELL, DEPUTY MARITIME ADMINISTRATOR, MARITIME ADMINISTRATION

Mr. BLACKWELL. Thank you. Good afternoon, ladies and gentlemen. It is a pleasure for me to be with people who take an optimistic view of the future of the American merchant marine.

This gathering today and my participation in it has several tinges of nostalgia. First, while I often come from Washington to New York on business, I very seldom come to Staten Island where you can get such a good view of Bay Ridge in Brooklyn, where I was born and raised, and which, incidentally, is represented by a very plain Congressman, Jack Murphy.

In addition to that, I am not a newcomer to this particular facility. I am sure that many of you in this role have been associated with this hospital for many years, but, believe it or not, I came to this hospital more than thirty years ago.

For one reason or another, most of the adult members of my family have sailed on merchant ships and most of them started to sail during the depression.

I think as far back as 1935 and 1936 I visited uncles and aunts and cousins in this hospital. Perhaps even closer than that, just two years ago, I came here to visit my mother, who was going to undergo a very serious operation, and that operation was successful. She had been thirty years in the American merchant marine on the passenger ships, and she is now healthy and happy and well returned in Florida. So that's another reason of being nostaigic about this place.

There is even another reason that I didn't quite realize until I took a good look at this program. In this graduating class is a man that I not only sailed with, but for a very short time roomed with when I was a purser. I think probably he has forgotten it, but Carl Woldman, would you stand up?

Do you remember?

Mr. WOLDMAN. I remember, yes.

Mr. BLACKWELL. You better remember.

As Burt mentioned, I was a member of the Staff Officers' Association and if you will bear with me a moment and if this program permits a bit of levity, I will tell you how I became a purser.

I was working with a railroad after graduating from college up in midtown and I was very, very unhappy, and having been to sea immediately after the war in the merchant marine as a sailor, and being a bachelor, I thought I would go back to sea again.

I thought I would try pursering, and every day I used to journey down on the subway with my little brown bag, pick up a container of milk and sit in what was then the headquarters of the Staff Officers' Association.

I think it was on Stone Street downtown. I figured if they saw me enough they would get tired of me and finally might offer me a job. Well, I did this for scores and scores of times and it wasn't having a great deal of effect.

One day I arrived with my stained little brown bag and just as I was coming in to bother them, Burt and an associate of his were leaving for lunch and they asked me if I would mind answering the phones, and I said no, I wouldn't mind at all.

No sooner had the door closed that the paymaster of the United States Lines called up and asked if there was a purser available and I said, "Yes," and he said, "Who?" and I said. "Me." And he said, "Can you sail on Thursday?" and I said, "Yes," and I just closed the door, went out and bought some uniforms and that Thursday I went to sea without even advising the Staff Officers' Association, because I had assumed, I think quite correctly, if they found out, they would have put someone more deserving and a chap who had more seniority on the ship.

You should have seen Burt Lanpher's face when he came aboard the America to collect the dues and he saw me punching out a payroll.

To enter this program, as these men did some nine months ago must have taken a good deal of courage, and it couldn't have been an easy decisiou.

To balance the certainty of earnings today against the uncertainty of additional earnings in the future is never a real easy decision. However, hopefully relying upon President Nixon's program to revitalize the American merchant marine, a program that is almost to be fulfilled, these men have indicated, as I have indicated earlier, optimism in the American merchant marine.

Incidentally, the President's new program just passed the House by an overwhelming 305 to 1 vote, and should be passing the Senate within the month.

I think a good deal of credit for that overwhelming vote to revitalize the American merchant marine goes to the House Merchant Marine Committee which so diligently worked on the legislation and produced a record and a package which enabled the House to vote on that bill in such an overwhelming fashion.

Of course Congressman Murphy is one of the hard workers of that committee and has also been a great supporter of the merchant marine. We think the overwhelming vote will help the bill to pass by a wide margin in the Senate.

As you know, the President has developed a program for the construction of 300 new ships in this decade, replacing the vast majority of ships in our present fleet that will have reached the end of their useful economic lives in this period. The ships to be built under this new program will be the most advanced, productive, sophisticated ships in the world. They will offer vessel operators the opportunity to be again competitive with their foreign counterparts.

Who will man these ships? Obviously, today's merchant seamen and officers will. While we do not visualize any massive change in the skill requirements for American merchant mariners in the decade now commencing, there will, of course, be some gradual changes probably tending toward an all-purpose seaman rather than one specializing in deck or engine.

It is only a matter of time until shipboard computers become commonplace. They will no doubt be capable of handling vessel navigation, monitoring engines and machinery, and keep the ship's records, among other things.

These devices will require skilled men to use them and to maintain them far at sea. Deck officers, engineers and pursers will have to become familiar with the capabilities these machines offer.

In recent months we in the Government and the industry have been discussing modifications to the training given future merchant marine officers at the U.S. Merchant Marine Academy and the State academies. We are recognizing that, in addition to the changes being wrought in shipboard duties and life there are other forces affecting the skill requirements for merchant officers.

We recognize that many officers and pursers do not spend their entire lives in shipboard jobs. Many of them come ashore to take positions in shipping management. The training they presently receive at the academies—being aimed as it is at shipboard duties—does not prepare these men for the responsibilities they encounter in executive positions. They must receive training for effective management, accounting, management techniques, marketing, and the other disciplines necessary for success in today's business world.

These officers may also go to sea aboard oceanographic research vessels. As this nation's concern with the oceans and their resources increases in the future, so will opportunities for merchant marine officers aboard research vessels.

But, again, present training programs do not properly equip prospective officers for these jobs. They will require far greater knowledge of the physical, chemical,

and biological aspects of the oceans, as well as close familiarity with the equipment and procedures used to extract this information from nature.

Aside from the changes brought about by the opening of new opportunities, such as oceanographic exploration, many of the changes in shipboard skill requirements that will occur over the years will result from efforts to achieve more and more operating efficiency.

Turnaround time will continue to be reduced, thus increasing the time a ship is at sea earning money. Vessel size and speed will increase also. These factors will mean that functions once performed when a ship was in port will have to be performed at sea. Primary among these is maintenance and repair.

I understand that some European shipyards have already created work parties that sail with a ship, doing what work they can while under way and preparing a ship to enter a yard to complete the work that cannot be performed while under way.

This is one alternative. Another is to have a crew with the skills necessary to perform much of this routine work aboard. These men could care for the ship and its components on a regular basis while the ship was under way rather than requiring special shipyard crews or extensive time in port.

In these few examples of what the future may hold for you and the other men employed by the U.S. shipping industry, I have not tried to exhaust the list of possibilities. Rather I merely want to indicate some of the more likely changes that will occur.

There are two trends that are apparent in these examples, I think. The first is the increasing number of skills required aboard ships of the American merchant marine in the future.

I have already mentioned computer technicians and metal workers. I am certain there will be others. At the same time these skills will be more sophisticated. They will require far more training than do those required aboard ships today. You, for an example, have just undergone nine months of intensive training to prepare you to perform a more sophisticated job, as pharmacist's mate, along with your duties as purser.

You have completed this training successfully and are now prepared to go aboard ship and to fill your new duties with the knowledge that you are in a good position, trained as you are, to benefit from the industrywide trend toward specialization and sophistication in duties aboard ship.

You are in the vanguard of this development. I think that the status of the certificate you receive today will be enhanced in coming years by another trend discernable in America today.

The national news media—particularly the news magazines and television networks—have devoted much space and time to the rising concern in this country with the quality of health care services. As the population's needs for livelihood, shelter and food are being satisfied in our growing economy, it is logical to assume that we as a people will devote more of our interest to insuring the quality of health care.

It is equally logical to assume that this concern will extend to the men who man our merchant ships.

Historically this nation has since its earliest days as a republic been concerned with the health of merchant seamen. This concern was first evidence in 1798, when provisions for federal hospitals for seamen were enacted into law. The continuing nature of the interest in this subject is apparent in the fact that federal care for seamen is still the law of the land. Last fiscal year, in fact, some 132,000 merchant mariners were treated in U.S. Public Health Service hospitals and clinics.

More important is the fact that life at sea is inherently hazardous. In addition to the fact that no one has invented an unsinkable ship, there are watertight doors that can slam shut on a man's hand; there are electrical connections that can come loose; there are booms and rigging that can break free. A pitching, rolling, constantly moving ship presents a host of opportunities for accidents.

All these, on top of the normal human frailties—ulcers, appendicitis, hangovers, et cetera. Government agencies, particularly the Public Health Service and Coast Guard, provide excellent assistance to victims of accident and illness. But there are oftentimes when they are too far away to be of immediate help.

A ship, therefore, must be able to offer some medical aid to the men who man it. We have depended on the knowledge of the ship's officers to handle this job in the past. But I believe that the advances in medicine, like the advances in

ship equipment, require more sophisticated training than has previously been available. The time when a man could remember what pills to give for what ailment, or had the time to match the patient's symptoms with those in a book, are coming to an end. Medical advances have made more effective remedies in greater number available to treat the large number of maladies to which modern man seems to be prone. To use less than the most effective health aids at our disposal is to offer less than the best possible care.

Linked to this problem of quality is the related one of cost. If we can find a system that offers equal or better care at less cost, then we certainly should pursue this alternative, assuming it is compatible with our free enterprise system.

The exact nature of an improved health care system aboard ship will have to be worked out between the parties most concerned—the men who man the ships, the men who own and operate the ships, and the Government agencies with jurisdiction over the subject, primarily the Public Health Service and the Coast Guard. But I have no doubts whatsoever that improvements in the health care system at sea can and will be made.

I base this belief on two facts:

First, the increasing interest generally in providing the best possible health services to all Americans will make all of us connected with the shipping industry more aware of the shortcomings of the present system—many of which this training program is designed to correct.

Second, the necessity for more highly skilled men to operate our ships will generate costs for operators in properly training them. It will, therefore, be more than ever incumbent on the owners to insure that the men are able to perform their jobs with a minimum of lost time. Improved health care at sea will help achieve this.

You have demonstrated skills in health care for use aboard ship. You have these qualifications, in addition to those as purser. And you have demonstrated the ability to learn and improve yourselves to meet future needs.

These three qualities—and particularly the last—will stand you in good stead in the years to come; I have no doubt.

It is therefore with great pleasure that I welcome you, with your added skills and responsibilities, back into the ranks of active seafarers. I wish you all Godspeed and smooth sailing in your newly broadened careers.

Thank you very much.

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REMARKS OF HON. JOHN M. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Congressman MURPHY. Thank you, Dr. Galluzzi. I certainly appreciate the introduction and to the graduates' relief I will say probably my remarks will not be as long as the introduction.

My first intimate association with the Public Health Service was on the battlefield. Our regimental surgeon and combat surgeon was a Public Health Service doctor who had been put in the United States Army for the very trying period of 1950 to '52, and therefore I am wondering and hoping that the difficulties the United States gets into in various areas of the world doesn't make it necessary to impress the new marine physician assistants into a battlefield role, the way the Public Health Service had to respond, has always responded in national emergencies.

Admiral Peterson, it's a pleasure to be here with you once again to discuss and listen, and with you, Burt, to Burt Lanpher, and to give you a little pledge right here, after listening to your remarks, and that is that the maritime education and training subcommittee of the House, of which I am the ranking majority member, will consider legislation to include this program, and this type of program under the Medical Technicians Training Act that we have been successful in passing.

In my other committee, which is the Public Health Committee, as Dr. Galluzzi so well knows, we will get action.

I don't know about this year, Burt. We have a very crowded calendar and we do hope to get to that legislation. However, in 1971 and, hopefully, I will be there to sponsor that legislation at that time.

This Public Health Hospital is certainly an inspiration to me and to Staten Islanders. I don't think there is any town or community in the nation that is so

oriented toward the merchant marine and particularly the personnel of the merchant marine.

From Sailor Snug Harbor to the Public Health Hospital, State Island is a real master of this profession. As such, I was happy to sponsor, to work for, and vote for and to amend the new Maritime Act of 1970, which the Deputy Maritime Administartor just outlined in detail.

One thing that wasn't stressed, however, is the fact that in the new merchant marine bill, which we expect the Senate to pass in the very near future, there are provisions to bring back under the American flag—let's call them the runaway flags—and those are the ships that American investors invest in and because of a difficult profit probably don't fly the American flag.

This legislation is going to bring back American flags so that we will have more flags flying under existing conditions, in addition to the multibillion dollar program of ship construction that Bob Blackwell just outlined, so we do have, I would say, better days and much better work opportunity and job opportunity in the maritime field.

For the first time in eight years that I have been in the Congress, management, labor and Government got together and agreed on a piece of legislation. In the previous Congresses there always was an awareness that we had a problem with American flags but it wasn't until this Congress when the triumphant labor, management and Government could get together, could agree on a program, could agree not to let's say put many special interest amendments in it, but to try to stick with a basic program to build American flagships as well as to lure back the American flagships to insure a strong and viable American merchant marine: the work opportunity for American men in all the trades and skills of the American merchant marine.

In my discussions with shipowners and with labor, the question always comes up as to the manning levels of American ships. The owners have said and have stated before the Congressional committees that with the new technologies, fully automated ships at manning levels that labor has agreed to, the United States can compete and can beat out foreign competition, but it is going to mean that the merchant marine, of the nineteen-seventies and eighties will have to be a much more skilled individual, and it is an individual skill that each man on a ship will have to possess. The skill that these men, these thirty outstanding graduates of this Fourth Class will bring to the American merchant marine industry, is something that is going to keep us competitive and it is going to certainly make the welfare and the safety of their shipmates, I would say, much better.

I congratulate them, I congratulate their families, and I wish them good luck and Godspeed in the future.

I would say that without the role of organized labor in the maritime training field, we might have been past the point of no return on ever having a viable American fleet. Not just the Staff Officers' Association, but the Seafarers' International Union who conducts its own training programs in every level of skill in the American merchant marine, from masters down to wipers and seamen, must be singled out and congratulated for the contributions they made.

American maritime labor filled the gap where the United States Government didn't fill the gap, and that is to provide quality training programs in their own facilities, where they paid seamen right up to masters to update their licenses and update their skills.

This has been a transitional period in the training of our maritime people and without the strong and early and quick activities in that training field, by American labor, as I said, we would have been past that breaking point and no amount of action by the Congress could bring back a viable merchant fleet.

Once again, congratulations to these men. I think we will see a greater emphasis on this program and other maritime training programs in the future.

The Public Health Service, who has performed a great deal of service not just to the individuals but to maritime labor and to the United States by assisting in the training program and the updating of the skill level of these men, my congratulations.

I want to say to the community of the Public Health Service Hospital, I think it is well known that I said the sons of public health officials who in some instances feel almost as if they are transients on Staten Island because they are only assigned here for a limited period of time, but I have the privilege to send

their sons to the service academies, indicating to them that they are fully and always considered as part and parcel of the Staten Island community.

We will continue to have that attitude at all times, Dr. Gailuzzi and you and your successors, I know, will always have that promise and, I am sure, make that contribution to the country through those service academies. Thank you very much for the opportunity to be here.

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REMARKS OF DR. PAUL Q. PETERSON, DEPUTY SURGEON GENERAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. PETERSON. Thank you, Dr. Gailuzzi.

Congressman Murphy, Mr. Lanpher, Mr. Blackwell, members of the families and friends of the graduating class, and to you gentlemen, it is a real pleasure for me to be able to be with you today for this graduating exercise.

I think it is quite appropriate that this exercise is taking place here in Staten Island and in this particular building. You will recall that this is the building that was constructed here in 1838; has served continuously as a hospital; as a research institute; as a training center for the Public Health Service.

It was turn of the century that Dr. Kenyon returned to this country from his studies in Europe and established in this building the laboratory that has now become the National Institute of Health.

It was here in this building in the nineteen-thirties and forties that Dr. Mahoney carried out his research which ultimately led to the definition of the use of penicillin, without which certainly the history of man and the history of medicine would have been different.

Those were first innovations in the history of health care of this country and although this is the fourth class to graduate from this course, which is similarly meaning so much to the health and well being of our people, it is a first because you will receive the Purser Marine Physician Assistant designation, the first time that this designation will have been used, and it is an appropriate recognition of the role and responsibility that you will assume in your work.

I bring to you particularly the Surgeon General's greetings and best wishes. He is in Russia. Before he proceeded to Russia from Geneva where he was heading the American delegation to the World Health Assembly, Dr. Egeberg and I had reason to call him and talk with him on the phone and before we finished that conversation, Dr. Steinfeld said, "Paul, it is next week, isn't it, that you go to Staten Island to be on the program of the graduating class there?" and I said, "Yes." And so, gentlemen, I bring you the personal greetings and congratulations from the Surgeon General of the Public Health Service, who wishes you well, Godspeed.

It is my great pleasure to be able to be with you, and to bring you this message from him. Thank you very much.

Mr. CONDIOTTI. I would like to correct some misstatements that were made this morning and nothing else.

There seems to be a feeling that the hospital itself is not really community oriented. Of course, the new legislation that Congressman Rogers mentioned would correct that to a degree. We must not forget, however, that the largest beneficiaries of the hospital, merchant seamen, is itself composed of vast numbers of minority group people, blacks and Puerto Ricans comprising a very, very large percentage of the U.S. merchant marine today. That itself is a minority. That's one point.

Another point in answer to a question that Congressman Kyros posed to Dr. Galluzzi, as far as what these men do when they graduate from the marine assistants program.

Dr. Galluzzi is a magnificent administrator and a very dedicated doctor but he doesn't know the workings aboard ship. Every one of the 112 graduates of the Marine Physicians Assistants School have come off a ship as a staff officer. This is pure error. They do paper work in

order to relieve the others to do more important duties and at the same time, surreptitiously, they did the medical work.

After coming here they now don't have to do the medical work surrepticiously. It's all done adeqnately, properly, and correctly. The majority of their time, 80 percent of their time is spent in their usnal paperwork and in doing their documentation for customs, immigration, and other abstracts.

Twenty percent of the time would be spent in the case of serious illness or very critical accident whereby that man's life might be saved, or a limb, or an eye, or minor parts of his body.

The one other point I did wish to make was when Mr. Thompson testified that 25 percent of the people in the physicians assistants program were from this group, I think he meant the medical assistants program.

I have nothing else to add to the program. I wish you gentlemen a very good lunch.

Mr. MURPHY. This will be a very short one, the committee has a very tight travel schednle. For any of you that would like to file a statement, my office is at 550 Manor Road, the general post office is open, and you know I am open 6 days a week to receive those statements.

Mr. ROGERS. Mr. Berlage, do yon want to make a qnick statement?

STATEMENT OF LEON W. BERLAGE, DIRECTOR, DISTRICT 2, MARINE ENGINEERS BENEFICIAL ASSOCIATION, AFL–CIO

Mr. BERLAGE. I am the director of planning, representing district 2 of the Marine Engineers Beneficial Association, AFL–CIO.

I want to thank you for the privilege of being here. If I sat on that hard seat much longer they could give me an award.

Gentlemen, I wish to say that I am against any movement or action that would curtail or close even one segment of the Public Health hospitals. I speak as a maritime representative. I am in full accord with the various other parties that will be affected by the unjust and immoral action of the closing of these most splendid institutions.

I will not attempt to speak for the Coast Guard, Government employees staff, and employees of this great establishment, nor the most deserving of all, the disabled veterans.

The fact that concerns my industry is the original concept of caring for merchant seamen. Like most old time union officials my education has been reenforced by association with management and trade. I even learned a few curse words, and at this stage of my life I am still being educated, but now by HEW Secretary Elliott Richardson, by the report that his Department was considering the closing of the Public Health Hospital.

I, as a student, many, many years through association with persons working with the merchant seaman's welfare, found in the first book of the second edition of the Law of Seamen, by Morris, at chapter 26, section 589, an interesting section. With your permission I would like to read this section which will take about 1 minute.

Mr. ROGERS. You may proceed.

Mr. BERLAGE. Section 589, U.S. Public Health Service hospitals are established and maintained. What is probably little known today is the fact that the first Public Health Service hospital or marine hos-

pital, as they were formerly known, were established for the benefit of the seamen and were maintained by a fund presented from a tax imposed on their earnings.

By the act of July 6, 1798, Congress provided that the master or owner of an American flag vessel deduct the sum of 20 cents per month out of the wages of each seaman employed aboard the vessel since they last entered any port of the United States.

This money was paid to the collector of the port to deposit in a fund created for the relief and maintenance of sick and disabled seamen.

The President of the United States was authorized to apply the money for the upkeep of these hospitals. Whatever surplus remained was used for the erection of new hopsitals.

In 1875 the amount deducted from the wages of seamen was increased to 40 cents per month. This method remained until 1883 when Congress repealed the prior act providing for the collection of a hospital tax for seamen and shifted the burden onto the owners by establishing a duty based on the tonnage of all vessels.

Thereafter, and until June 30, 1906, the expense of maintaining hospitals for seamen was paid out of tonnage taxes.

On June 30, 1906, the expense was directed to be paid out of the General Fund of the U.S. Treasury.

Gentlemen, I am sure you know this. I wanted it for the record.

I wish to point out that it was the seamen and shipowners through their dollars who created and supported this service for 106 years. It was the Congress of the United States who directed in 1906 that this service would be borne by the general funds of the Government.

It seems to me it should take an act of Congress, not the Department of Health, Education, and Welfare to change the direction ordered by the Congress.

In closing, I would like to repeat at this time that my union is in complete accord with all other interested parties. To go down the line, if necessary, hit the bricks, which is my language, to walk the pavement, and take whatever action is necessary to defeat this irresponsible act of depriving our sick and injured seamen of the haven they created in 1798.

I suggest you send the Marines down to see our Secretary Richardson.

Thank you very kindly, sirs.

Mr. ROGERS. Thank you.

Of course, the committee feels that there is an obligation to keep these hospitals open to provide the service, and we feel if there is any change there should be a congressional intent to do so.

Mr. BERLAGE. Very happy to hear that, sir. I am very glad to meet some more champions, because Congressman John Murphy has always been a champion. His door is always open to us, and I hope you gentlemen keep your doors open to us also. [Applause.]

STATEMENT OF DR. DAVID McLANAHAN, FORMER STAFF PHYSICIAN, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. MCLANAHAN. Before you terminate you have an obligation to listen to some dissidents testify.

Mr. ROGERS. Yes.

If you will, identify yourself for the record.

Dr. McLanahan. Dr. David McLanahan; I worked here for 3 years. For the past 3 months I am working at another Staten Island hospital. And I think from this overview I have a unique position to offer some comments about some of the preceding testimony concerning the efficiency of the hospital.

In some of the community service and utilization——

Mr. Rogers. May I ask this: Are you presently working in the hospital?

Dr. McLanahan. Another hospital; not this one. I finished in July.

Mr. Rogers. You are no longer with this hospital? What we are trying to get at, as you know, is really whether the hospital should be open or whether it should be turned over to some other group or closed.

I don't know that we are going to have a lot of time to go into every detail of the administration of this particular hospital. I think it would be helpful on that if you would put it in writing on things you think need correcting in the administration of the hospital.

But, in order to save the committee's time, we are not going to try to get so much into the administration, but on the question of whether all of these hospitals should be closed or maintained.

Dr. McLanahan. I think I can make my comments brief. First, I would like to say the essence of my feelings and of other people is that this hospital should remain open. However, the essence has to be service to the community and community control of the service in the form of responsibility of the people administering it. Go to the real community people and not community people that have been more or less set up and picked by those administrators.

I think the first part of this hearing has been carefully programed to reflect one side of the situation, mostly dealing with the question of, does this hospital serve the community.

I think it has been mostly relative to the potential of this hospital to serve the community rather than its past performance which, myself, having worked here for about 3 years, and many, if not most, of the Staten Island community people agree with me, that it has been tremendously inefficient and has not dealt with community problems going on in the community.

Mr. Rogers. May I just interject at this point?

Really, the authority under the law of the Public Health hospitals has been rather restricted on what they can do in a community activity. I said in the last Congress now we have tried to broaden that. The law has not yet been implemented but they are coming with a request for $10 million right away which will then give us a basis to do some of this.

We agree, we hope we can get into this area of expanded community involvement.

Dr. McLanahan. As far as past performance goes, you have had a lot of people talk about individuals treated here and it has happened on an individual basis. But being one on the inside I have seen a few patients trickle in daily. Ones that are not emergency cases, patients in pain, have mostly been friends of doctors. I think everyone working here will bear me out, nonemergency cases, emergency cases trickle in.

I have worked in another hospital. I referred people here. I know it's quite a hassle to get a house staff physician in another hospital

trying to get somebody in here at night. It might be easier to stay the daytime.

Also, working in another hospital, I am familiar with the [illegible] where I work there are about 60 to 80 people on the waiting list classified as nonemergencies, but nevertheless, patients who have gall bladder attacks, who are in pain, who have strokes, often have to wait. The severe ones have to wait a week or two.

That's one aspect. The other one is, I think, that this hospital is very inefficient compared to other hospitals. We have heard that where I work I would say 100 a day, or it might be lower, it might be only 60, yet I remember a story in the Staten Island Advance a month or two ago which said patients in this hospital stayed four times as long as they do at Staten Island Hospital and St. Vincent's. I am not guaranteeing the figure four times as long is perfectly accurate.

However, having worked here and know the surgical department operations are usually delayed 5 to 7 days before the patient was taken in the operating room and they stayed in much longer than where I work now, where patients are in one day and operated next, and out more often than not, too early, to make room for other patients coming in.

That's how doctors make money, more rapid turnover. At this hospital new physicians are told, not obviously, but known to them, that it is in the interests of HEW to keep patients in the hospital. There are various forms of deception such as discharging a patient 2 days later, actually they go home, sending them on a pass, but the hospital knows they will get paid for 2 days.

I think $60 a day is not an accurate figure because being here several times as long as they need to be, they don't need the laboratory work that—and physician care, and so on, and supplies that they need at the other hospitals. I think the opening remarks at the hearing today were very accurately reflective of the capability of an institution like this, which is a bureaucracy where the prime concern of the bureaucrat is not rocking the boat.

I think everybody here saw that crystal clear.

When this hospital changes its present status, and we feel that it will, we want to fight this bureaucracy. The only way this can be done is in the form of community control where the people who run the hospital are responsible to the people that are the consumers of health care.

One way this could be done is by some kind of rule where the administration would be subject to be recalled by the community when they have been shown not to be acting in the interests of the community.

That's all I have. [Applause.]

Mr. ROGERS. Thank you very much.

Anyone else like to make a statement?

STATEMENT OF OLGA DEJUANA, REPRESENTATIVE, COALITION FOR A STATEN ISLAND FAMILY HOSPITAL, STATEN ISLAND, N.Y.

Miss DEJUANA. I represent the Coalition for a Staten Island Family Hospital. I have a brief statement I will read.

Why is it that an important meeting to help to decide the fate of our hospital was announced only yesterday afternoon? Yet, all the professional Staten Island spokesmen have already presented their statements, and are here today with priority time on the agenda?

When we called Congressman Murphy's office we were told that we probably would not be able to speak for lack of time. It's the same old story, big shots only talking to big shots.

Not only were we not notified about the hearing but it is being held during working hours guaranteeing that only big shots will show up.

We will not take part in any hearing in the future of the U.S.P.H.S. hospital until it is held at a convenient time with at least 1 week's notice.

We are tired of being railroaded on this issue. Every day the newspaper has articles about how this or that has happened to turn the thing around again. An atmosphere of complete chaos, confusion, and contradiction has been created.

This hearing just adds to that atmosphere. It pushes us, the taxpayers, into the role of mere spectators.

The Coalition for Staten Island Family Hospital is determined not to be a mere spectator while the big shot magnates talk marine hospitals. We are an alliance of community people, workers, and students dedicated to transforming our so-called Public Health Hospital into a health center for Staten Islanders which will provide the kind of service which we desperately need.

Comprehensive family services emphasizing prevention and women's services, complete youth service for students and workers, and community youth. Complete service for the elderly with emphasis on home care programs, 24-hour wide open emergency rooms with ambulance services, complete addiction treatment programs without police intervention. Health day care services for both in- and out-patient. Community services for the retarded, including evaluation and home and hospital supportive services. Community mental health service for day hospital and psychiatric intervention.

We know that the plans being put forth by the bureaucrats and politicians will not meet these needs. It is becoming clear that the basic plan is to quietly shift the control to those who, in the words of Dr. Egeberg, show evidence of professional and financial resources for stability and efficiency.

In other words, private doctors and Dr. Banker supporters.

Our coalition says that only a publicly funded community hospital can provide these services that we need and only a hospital which is accountable to the people that it serves will meet our needs.

Every hospital in this big city uses people and their illness to make money. Every time people talk about the community they are talking about all of us, but not for us to say, because we are not organized. We do not have the unity and power yet to determine our own destiny.

Why is this so? Because we, the common people, are always manipulated right and left. We are told lies, we are purposely divided so that a small group of business-type tycoons can keep destroying all our wealth, block all our needs, and put our interests—and put their interests first.

There is not a single hospital in all of New York that offers the essential services to the people that will keep them healthy in their homes and in their community.

Health is a social and political matter. For us a healthy family lives in a healthy community.

Looking at our communities broken with drugs, housing usually unfit for people to live in, streets filled with garbage, and violence everywhere, we find we are expected to pay, and pay, and pay, and get nothing.

The Coalition for Family Hospital is more than anything a defense organization. It was born because we, the common people of Staten Island, needed to be defended against illness. We see this beautiful hospital and we say it must belong to all the people of Staten Island and not be held for the exploiters.

We demand that if Congress wants to hear what the people have to say that they hold truly open hearings announced a week ahead of time when workers, students, and community people can attend and speak out about their needs and desires. Then you will hear for yourselves what the people want, this hospital intact. You will hear that they want it fully supported by public moneys which we already pay in a thousand and one taxes here in New York City.

They will never tell you in detail that the administration of this hospital has never been interested in the community and has a record of racism and antiwork practices that year after disgusting year are continued.

These people here today will never tell you that.

We of the coalition say that whoever is the public agency that sponsors our family hospital must be an instrument to serve the people, machinery must be established to make sure that people who walk in and take the bus and who do not drive any limousine to come here for care, have the power to make the hospital be one that serves all the public properly.

The eight point program is our basis for organizing our community. They will join together around what is now an interest of the majority in a true democratic way to fight against a minority who now controls it.

People of Staten Island will be won over out of isolation and fear and feeling of powerlessness. Your Congressman can help—you Congress can help or you can become part of the problem. The choice is yours, but this hospital is ours. [Applause.]

Mr. ROGERS. Thank you very much for your viewpoint.

It's my understanding that the statement we would be here was in the Staten Island paper 2 weeks ago. It was in the paper yesterday. This is only 1 day, as you say, but we are glad to have you here and to hear your viewpoint.

Yes, Mr. Thompson.

STATEMENT OF CHRIS THOMPSON, STUDENT

Mr. THOMPSON. My name in Chris Thompson and I speak on behalf of some concerned students who have been involved with various community projects and also in dealing with some of the medical problems of the community we have set up a community health center to begin service the poorer people of Richmond.

I say, first, that speaking to this subcommittee is somewhat contradictory because I feel that the words I have to say will have very little effect, because the subcommittee appears to me to have set up a situation where it is conducive to certain views being expressed and the majority of the people who are capable of coming to this meeting have certain interests in this hospital functioning the way it is. And that it is impossible for people who have other interests to appear at these meetings.

Now, there is one thing I would like to bring to the attention of the committee and that is that sometime ago there was testimony given by the workers of this hospital. This was a committee of community people who set up an investigation of the hospital. At this, 16 various organizations of people testified. This testimony documented very firmly a lot of the problems that the hospital has.

During the documentation of this and further releasing of this information it became part of the property of our beloved community corporation. The community corporation which says it has so much community mindedness that it will not release the testimony in the interests of its constituents.

I feel that the effort of this committee should be to get those documents and examine them and find out why a lot of the people who testified in those hearings are not in this room today because they have been fired. And what can be done to help these people, maybe achieve reinstatement or receive some compensation for the justice in speaking out against some of the programs at this hospital.

I think any kind of response—are there any questions about that?

Mr. ROGERS. I am sure there may be some questions.

Have you completed your statement?

Mr. THOMPSON. No, I haven't.

But I mean as far as the fact that the Community Corp. of Staten Island who I feel is in cahoots with a lot of political politicians on this island that can keep the documents suppressed and hidden, kept in the community corporation's safe, should be approached by this committee.

And it is my understanding that a community public service branch cannot withhold public information. I think it's illegal and a very underhanded tactic and also shows this committee really where their true interests lie, how they are afraid of the truth coming out.

Mr. ROGERS. Let me say this:

We are up here to try to be helpful. That's why we came. We didn't have to come. We came up to try to be helpful because they were about to close down this hospital. We don't feel that's a very good thing to do for the community.

Now, I think also you should realize that the Public Health Service Hospitals were set up to give service to those in the Merchant Marine, the Coast Guard, and certain Federal employees. They were not set up for a community hospital. They have no authority under the law for that.

What we have tried to do now is to do what you are asking. We have broadened the law in the last Congress where we can go in and try to be helpful to the areas in the community where they don't have health care so that they can use the Public Health Service Hospitals, too.

What I am trying to say is that it is going to take a little time to implement that law and because they have not had the authority to do this before, I am not sure we are truly justly criticizing them where they could not under the law do it in this particular hospital.

Now we are trying to broaden that and I hope to cure some of the problems.

Mr. THOMPSON. Speaking in particular in terms of this testimony which I think is a very relevant part of this hearing——

Mr. ROGERS. Who had the testimony? Does it bear on opening or closing this hospital?

Mr. THOMPSON. Yes.

Mr. ROGERS. Well, we will be glad to have it.

Mr. THOMPSON. The Community Corp. would be able to answer.

Mr. ROGERS. We will be glad to have it, certainly.

Mr. THOMPSON. I would like to know is it illegal for a public organization to withhold public testimony?

Mr. ROGERS. I can't speak for them, or the Congress, when it is public testimony, it is public testimony. You have to direct that question to whatever group or organization conducted the hearing. But for the Congress, if it is a public hearing, it is open to the public, of course.

VOICE FROM THE FLOOR. I am a member of the citizen's panel which held hearings in November. I think Mr. Thompson is talking about the staff director of the federally funded quality agency here who is holding that testimony in a safe refusing to release it for publication to the community.

Mr. ROGERS. I think you should go to the head of that agency and ask that it be released if it should be.

VOICE FROM THE FLOOR. Mr. Thompson is asking for you to do that because it would be enlightening to see the kind of practices going on in this hospital both as to personnel and as to its patients.

Mr. ROGERS. We would be glad to ask for that.

VOICE FROM THE FLOOR. The issue is not that there was an attempt to force the hospital to take in more community patients, the hearing was held around an area where workers were fired or suspended arbitrarily. When complaints came to us, community people looked into the situation, nobody else was taking the initiative to do it to get the workers' jobs back.

Mr. ROGERS. We will be glad to ask for that report.

Mr. THOMPSON. My main point is to use the emphasis of the unaccountability of the corporation to the people of Staten Island.

Mr. ROGERS. Of course that's not our jurisdiction; that's a local corporation. We really have nothing to do with that. I wish we could be more helpful but we have no jurisdiction. I think you should go directly to them.

Thank you, Mr. Thompson.

STATEMENT OF DR. MICHAEL WILKINS, FORMER STAFF PHYSICIAN, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. WILKINS. I am Dr. Michael Wilkins. I worked here 3 years. I was fired last July. Ever since then I have been working on Staten Island.

I would like to concur with some of the people here at the difference in being—I am kind of disgusted with the intention of this committee which was perpetrated by you, Mr. Rogers, at one point in which you said you felt obviously the hospital would remain open as a Public Health Service Hospital.

You have at several times said, "We are your friends, we are here, we came here trying to keep it open," you know.

Mr. ROGERS. Do you want the hospital closed?

Dr. WILKINS. No.

Mr. ROGERS. That's what I thought you said.

Dr. WILKINS. But I have questions about your overall sincerity that I would like to bring out.

Many of the working people and young people in this country are very upset with the rulers in this country. You fellows sit in Congress and create certain contradictions which you then go back and attempt to solve.

Mr. ROGERS. We are trying to keep our hospital open, sir.

Dr. WILKINS. There are several reasons why people are very upset with the rulers of this country. One——

Mr. ROGERS. Let me say that I don't think we can get into settling the upset of people in the country. That is always going to be so. Some people are not going to agree with what the Government does.

Dr. WILKINS. You are not allowing me to speak to certain contradictions in your position.

Mr. ROGERS. It may be contradictory trying to be helpful here. We came here to try to do something to keep this hospital open so that it wouldn't be closed, so that people wouldn't have any place to go. That's what the committee is trying to do [applause].

Dr. WILKINS. Certain policies of the current administration——

Mr. ROGERS. We are trying to change them.

Dr. WILKINS (continuing). Caused this problem to exist.

Mr. ROGERS. We are in the Congress, not the administration. We are trying to change them.

Dr. WILKINS. Sixty percent of the U.S. budget is for military purposes, you see. That's something that you all vote for [boos]. That is where the money goes.

Mr. ROGERS. I will tell you honestly. I don't think we can spend a lot of time getting into that particular phase in these hearings.

Dr. WILKINS. You totally miss the point if we ignore the fact. That's why this crisis exists.

Mr. ROGERS. We are trying to put a priority on health.

Dr. WILKINS. You are not.

Mr. ROGERS. I am afraid this gentleman doesn't know what we are personally doing. We have got legislation, we acted on legislation, we just passed the Emergency Health Personnel Act.

Dr. WILKINS. You want more for the Defense budget and you want taxes to pay the same, and it is all impossible.

Mr. SYMINGTON. I would like to remind the gentleman actually, believe it or not, this isn't the first time any of us have heard the kind of presentation that you are making. And many of us make similar ones at the appropriate times for us.

Only last year there were a number of bills proposed in the Con-

gress and some were vetoed and some were not. One of the ones vetoed was a hospital bill.

Mr. ROGERS. That was my bill, incidentally.

Mr. SYMINGTON. Now, that was due to the judgment of the administration about the allocation of resources for that particular purpose at that particular time. Reasonable men can differ. The Congress can differ, and we overrode the veto.

Also, don't feel that your point of view is unreflected by people who have been elected. It is a complicated matter, but I wouldn't have thought that this committee in any way has revealed today its lack of concern or lack of interest in the health field.

STATEMENT OF EMILIO SEPA, PATIENT, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Mr. SEPA. My name is Emilio Sepa. I was in the Army, then I was a merchant seaman for about 25 years. I retired. I have been coming to this U.S. Public Health hospital since 1948, back and forth. I have been coming over here in a critical condition. Thanks to the doctors here and the nurses and other staff, I am still alive.

And I wish we would fight to the end. We are going to keep close to Congressman Murphy to keep this hospital open for the rest. I don't care what anybody says.

I like to say I disagree with the borough president when he made his statement and walked out. I don't understand why he said the Federal Government hasn't any money to fix this hospital. I got some ideas on how they can get some money. I know where they can get it. They can get it to bring more doctors, more nurses, more staff, many other people here. Let Mr. Richard Nixon and all these characters in the White House and let all these characters in Albany bring all these ships, they got in 40 flagships and American ships in Broad Street, 17 Battery Place, because I know everyone there. They have Monrovian flags, they have Italian flags, German flags. They do that to avoid paying taxes to the U.S. Government, No. 1. Do this to avoid paying the regular wages to the American working seamen.

Why don't they run away with that? They got money. Now, I do not count the Governor of New York State or the mayor of New York City because these two characters are in the middle of the ocean, they try to see to save their lives. They don't know which way to go to save it.

Same thing like Richard Nixon, Agnew, they do nothing. Agnew playing ball and Nixon swimming and fishing [laughter].

Have these people sit down and talk about this once and for all. I would like to finish. I like to advise Mr. Richard Nixon to sit down, whoever gave him these ideas to close this hospital which belongs to us. Let him sit down, talk about this once and for all because it cause big disturbance not only in New York but the whole 50 States.

And if we have to go with Congressman Murphy, stay there, sleep in, to fight this case, because he is the Congressman to do something about our situation. I am behind him 100 percent.

Mr. ROGERS. That's a good statement. Thank you.

Do you want to speak? Please be brief, we are running behind.

STATEMENT OF DR. JAMES FIELD, CHIEF, DERMATOLOGY DEPARTMENT, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CLIFTON, STATEN ISLAND, N.Y.

Dr. FIELD. Dr. James Field, chief of the dermatology department.

Mr. Chairman, distinguished members of the subcommittee, I have heard concerned voices for primarily priority care for merchant seamen, coastguardsmen, and Federal employees at the hospital. I feel I would like to make you aware of a small group of primary beneficiaries of the Public Health Service whose protean needs concern me just as much as the medical needs of these other individuals.

I am speaking of people with leprosy. We worked very hard here over the past 10 years to develop a good program for the needs and physical rehabilitation of patients with leprosy. There are an estimated 300 to 500 individuals with this disease in New York City.

This hospital is used as a facility for the hospitalization of these individuals who require it. We also run a very active outpatient service for patients with leprosy.

I just wanted to make you aware.

Mr. ROGERS. Thank you, Doctor. We don't mean to overlook you. We were aware that the Public Health Service has the obligation and is doing a fine job.

Louisiana and a clinic in my State in Miami is handling some, and San Francisco, as I recall, too.

Dr. FIELD. There is a great desire and move underway in recent years to have these patients cared for in their own local area rather than to put them in central areas.

Mr. ROGERS. Thank you.

STATEMENT OF JULIE REED, AD HOC COMMITTEE OF ONE, FIGHT MEDICAL DELINQUENCY, WRITE YOUR CONGRESSMAN NOW COMMITTEE, STATEN ISLAND, N.Y.

Miss REED. I am an ad hoc committee of one called Fight Medical Delinquency, Write Your Congressman Now Committee.

I am going to see to it, just as sure as I am sitting here, that you are going to get letters, I tell you, like you have never had before on this subject.

Mr. ROGERS. May I say that your Congressman is doing a good job. Already we have had 40,000 that he presented to the committee. So we are delighted to receive them. And people here are very much aware of their concern.

Miss REED. On this point, sir, the kind of desensitivity we have in this country, the destruction of our country, I say to you, sir, is imminent. It's imminent from the history.

Mr. ROGERS. May I say this: I don't believe we can get into all of this in this hearing. We are trying merely to restrict us just to whether we should open or close the hospital, or what we should do.

We do appreciate your being here.

Miss REED. One moment, sir.

Mr. ROGERS. I need my moment before you.

Miss REED. I have been working on this for 6 years. Three years ago I heard of the U.S. Public Health Service—3 years ago. The first

time millions of Americans have ever heard of this Service which is literally socialized medicine for a capitalistic industry. Is it not?

Mr. ROGERS. It is an obligation of the Government to provide the service we do to our merchant seaman.

Miss REED. However, this is unequal protection under the law.

Mr. ROGERS. We try to give equal protection and see that everyone who was entitled to care gets it.

Miss REED. Everyone in the United States is entitled to care, sir. It is not only seamen; it is not only seamen, sir.

Mr. ROGERS. There is an obligation of the Government to provide seamen. We have done this since the beginning, or 160 years ago.

Miss REED. But the people of the United States generally have not known they have been providing it.

Mr. ROGERS. Let me say this, are you for the closing or against it?

Miss REED. I am against the closing, and I am for the suspension—1 moment, please, don't cut me off.

I am for the expansion of the U.S. Public Health Service in every single State, in every single county, in every single city, village, and township in the United States of America.

About this confusion and contradiction others have spoken about here, sir, we are not so stupid. We know about that $70 billion a year medical-industrial-corporate complex. We know about that. We know about big business, having us over the barrel, and medical doctors now at the head of a medical monarchy, if you please. They are not equal to us; they are unequal. They are a monarchy with absolute rule who say who should live and who shall die in this country. They have us over a barrel. [Applause.]

They give the American people a good swift kick.

I have gone about making personal interviews, surveys. Three out of 55 people say in answer to the question, "How do you think we should take care of medical care in the United States?" The answer is, "Socialized medicine." If you don't give it to us, sir, in the arena of social warehouses, which is what medical care is today, this is where the great internal trouble is. Where blacks go against whites; where whites go against blacks. Where non-Jews go against Jews, and where Jews go against non-Jews. This is where we can tyrannize one another in a closed situation. This is what has happened.

I speak as a person who has been physically assaulted in the hospital——

Mr. ROGERS. Do you live on Staten Island?

Miss REED (continuing). Beat up by hospital employees.

I do not live in Staten Island.

I have my first-amendment privilege, if you please, sir, and I assert it here and I am going to continue to assert it. I may seem ridiculous to you.

Mr. ROGERS. No; I don't say that.

Miss REED. But every single one of you is going to get letters, I tell you. You're not going to cut us off; we are not going to be ambushed by the big medical-industrial-corporate complex with medical doctors and medical doctors as medical anarchy.

Mr. ROGERS. May I say this to you: This is not a hearing on whether we will have socialized medicine or not. This is a hearing on whether the hospital should be kept open or not.

I appreciate your viewpoint and we are glad to have your letters and we are grateful to you for being here and expressing your viewpoint.

If there is anyone else who wants to testify, if not, let me say this: We appreciate the patience of all of you, your kindness in coming and being here, and letting us have your viewpoint. It is helpful. We are trying to do something. We are going to continue to expand the Public Health Service of the United States.

Thank you all for being here.

(The following statements, letter, and newspaper article were submitted for the record of the New York, Staten Island hearing:)

STATEMENT OF ROBERT J. O'CONNOR, M.D., CHAIRMAN, SUBCOMMITTEE ON HEALTH FACILITIES, STATEN ISLAND CHAMBER OF COMMERCE

Gentlemen, I am Robert J. O'Connor, M.D., chairman of Sub Committee on Health Facilities of the Staten Island Chamber of Commerce.

The Chamber is concerned about the lack of adequate medical facilities in this community. The Island has 300,000 people and this represents population increase of approximately 36% from 10 years ago. Projected population increases indicate a population of 522,000 people in 1985.

Staten Island is growing rapidly, but health facilities are not growing fast enough to keep up. Present indications are that the Island is short 700 hospital beds.

The Public Health Service Hospital on Staten Island fills an important need. All Island hospitals rely on the medical expertise and advanced equipment and research at the Public Health Hospital, as well as bed space it makes available to patients needing emergency care. This borough's other hospitals are operating at or over capacity. We need increased medical facilities, not decreased.

Many services are provided by the Public Health Hospital on Staten Island. Some facts about it are:

It serves 420 patients per day.

It serves 140,000 out-patients annually.

It provides emergency medical service to the public.

It provides physical examinations and laboratory tests for a number of local agencies.

It provides desperately needed nurses training.

It provides desperately needed dental lab technician training.

It provides desperatel yneeded dental lab technician training.

It provides unique medical assistance for onr other hospitals and their staffs.

If this hospital is closed, who is going to fill the huge gap created by its absence? Certainly no other facility on our 60 square mile Island can provide the medical services, and other nearby New York City hospitals are already crowded.

Staten Island needs the Public Health Hospital and the Staten Island Chamber of Commerce urges—as strongly as possible—that it be retained.

In closing, I want to casually mention the economic affect of this hospital in our community. I say casually because if economic loss were the major reason for keeping the plant open, the Chamber would be hard pressed to favor retention, when it has been urging economy and sound business practices in government.

However, since the Chamber believes the medical services here alone justify the hospital's existence and its continuation, the economic impact is an important sidelight.

The payroll of about 11 million dollars annually, ranks with the Island's largest industry. The nearly 1000 jobs presents a dramatic chain of events that is often overlooked and I'd like to briefly draw your attention to this significant aspect.

The U.S. Chamber made a study several years ago and while the figures are not current we believe they are representative.

1,000 people working here requires more employees in other fields. It adds 190 jobs in wholesale and retail trades; 60 jobs in business and personal services; 50 jobs in construction; 40 jobs in finance, insurance and real estate; 20

jobs in transportation, communications, and public utilities; 140 jobs in other industries.

It adds 3 million dollars in bank deposits, 30 more retail establishments, nearly 1000 automobiles, and nearly 3½ million dollars in retail sales.

That, gentlemen, is a summary of the economic picture, and I will conclude my remarks by urging you to retain the U.S. Public Hospital on Staten Island.

STATEMENT OF MRS. KENNETH SORGE, SECRETARY, REGULAR DEMOCRATIC ORGANIZATION, AND VICE CHAIRMAN, COMMUNITY BOARD NO. 4, BOROUGH OF RICHMOND

Gentlemen, I am Mrs. Kenneth Sorge, secretary of the regular Democratic organization of Richmond county.

In the interest of time, I will not only speak for the Democratic organization but also for Community Board No. 4, Borough of Richmond, of which I now serve as vice-chairman. This board encompasses an area covering most of the south shore of Staten Island.

I will try to be brief and to the point. This hospital must not—and cannot be closed!!!!

It angers me to have to even officially recognize the ridiculous recommendations of an obvious incompetant committee who would even think of entertaining a motion or closing these valuable doors.

One's first reaction to such a criminal though would be that possibly this committee's membership should seek admission as patients to the EF-3 ward of this hospital, which if things haven't been changed around since I worked here, is still reserved for the emotionally disturbed.

Strong words? True! But there is no beter way to express the frustration, anxiety, and anger this committee has created for the residents of Staten Island.

Gentlemen, Staten Island cannot do without this facility. As past-president of the Woman's Auxiliary of Richmond Memorial Hospital, Staten Island, I call to your attention that we are now operating at a capacity of 119 percent—the other voluntary hospitals operating at about the same percentage.

Correct me if I'm wrong but isn't 80 percent the danger level of capacity? So therefore, the next question would automatically be, how do we do it? We could not, if this hospital is closed!!! Because of the overcrowded conditions that exist at all hospitals on Staten Island, most of our overflowing patients are sent here. In many cases, the results have involved saving a life.

If anything, this hospital should be expanded and authorized to treat certain specialized illnesses that only this hospital is equipped to handle and all others on Staten Island are not.

I read in one of the articles concerning the possible closing of this facility that the investigating committee cited "out-dated" equipment as one of their reasons for their decision. I must comment that if the equipment in this hospital is labeled out-dated, then all of the other hospital's equipment on Staten Island must then be rated ancient!

Sadly, time does not permit me to elaborate on the employment at this hospital nor does it give time to point out the effects on the hospital that the proposed south Richmond plan will have including plans to add millions to the population just the south side of S.I.

Gentlemen, I rely upon your wisdom and experience and personally invite you on a tour of all our hospitals on Staten Island.

Your decision then could only result in a positive approach for the future operation and possible expansion of this hospital.

Thank you.

STATEMENT OF ROBERT E. LANNING, STATEN ISLAND REAL ESTATE BOARD

Gentleman, I am Robert E. Lanning, speaking for the Staten Island Real Estate Board and for its President, David Endervelt in support of the position of Congressman Murphy.

We, quite obviously are interested in Real Estate. Obviously the economy of our community affects our business and this facility affects our economy.

Additionally we take a professional look at the use of Real Estate and we call best value as being derived from the highest and best use of land. It is obvious to us that the highest and best use of this land is its present use, as a hospital,

and, as was stated, the only body that could administer it is the Federal Government.

If we were asked to appraise it for present value—being in use and hopefully near capacity, we would calculate the land value, then add the value of the improvements (which are considerable) and also add if possible the imponderable—the amenities and use it gives the community. This would be difficult but I'm sure you can see that value in use would be more than the value closed.

If we were asked to appraise the empty facility (not in use) we would calculate the land value and then subtract the cost of demolishing and removing from this land the buildings which would not lend themselves readily to other uses.

Of course we agree with all of the other speakers on the value of health care but we can also appreciate the dollars and cents of the property in each case.

Thank you for your attention.

STATEMENT OF HARRY HADLAND, CHAIRMAN OF SCIENCE, SUSAN E. WAGNER HIGH SCHOOL

Gentlemen, for the past two years the Science Department of Susan E. Wagner High School and the staff of the United States Public Health Service Hospital have been actively engaged in a highly innovative educational endeavor. The program is called the "High-School Hospital Health Careers Program. Its prime objective is to articulate High School graduates with college and, subsequently to provide the student with gainful employment in a paramedical profession, e.g. Laboratory Technicians, Dental Hygienists, and Physical Therapists. In essence, we are striving to eliminate two burgeoning problems. They are: (1) A nation wide escalation of the need for para-professionals to support the medical specialist. Current figures indicate that 10 support personnel are needed for every doctor. The figure is expected to rise to 25 within the next decade. (2) Our Island High Schools reflect a drop-out rate that is less than the other four boroughs of New York City, however, the figures are still alarming and do reflect a national trend. Slightly more than 1 out of every 10 students who enter High School, never finish High School. In addition, less than forty per cent of Staten Island's High School Graduates move on to College.

Our High School-Hospital program deals directly with the borderline academics that may opt to discontinue their education prior to graduation. We select students that fall into several "dropout" syndrome categories. They are: The student displays a consistent record of under achievement and failure, and/or a spotty attendance record and/or may be considered culturally deprived. The school is usually placed in the position of compensating for cultural disadvantages created by a low socio-economic background. These conditions need not determine entrance into our program. Many underachievers are innately talented individuals who need the motivation and the prestige that our course provides in order to complete their education.

In the Fall of 1969, sixty students entered our Laboratory Techniques course. (Lab Techniques is a prerequisite for the Health Careers course. The High School-Hospital Program is offered to students in their Senior year). Approximately 50% of these students are currently enrolled in the Hospital Program. The remaining 50% were directed into other elective subjects. All of the students will complete their High School Education. All of the students who opted to continue with the Hospital program will receive direct admittance into the Staten Island Community College. In addition, the hospital will supply them with employment over the summer. They have also agreed to support the students with part-time employment while they are in College. The United States Public Health Hospital has given our High School the opportunity to better serve the youth of our community. Without the United States Public Health Service Hospital and its staff, twenty-eight students may have dropped out. Without the Hospital, 28 students could have become a drain upon society. With the Hospital, 28 students will become a constructive force in our community. Further consideration of our program leads to an interesting proposition: If the United States Government were to support this program on a nation-wide scale, the number 28 could become 280, 2800, or 28,000. It certainly should not be zero.

THE COUNCIL OF THE CITY OF NEW YORK,
Staten Island, N.Y., March 12, 1971.

Hon. JOHN M. MURPHY,
Member of Congress,
U.S. Public Health Service Hospital,
Clifton, Staten Island, N.Y.

DEAR CONGRESSMAN: Because of the pressure on the Finance Committee of the City Council to present the Capital Budget for the year 1971 and 1972, I am unable to appear at the important hearings being conducted by the Congressional Committee this morning. However, Congressman, you are well aware of my sincere interest and support of your tremendous efforts to keep the doors of the United States Public Health Service Hospital open to patients in this metropolitan region.

At your request, I traveled, together with my fellow Staten Islanders, to hearings in Washington, in an effort to convince Officials in that city, of the desperate need to continue the health benefits that have been exteuded by the United States Government, for so many years.

Congressman, were I able to be in attendance today, I would extend to the members of the Committee, my public thanks to you, for the effort you have made in Washington and in Staten Island, for the benefit of our people.

I sincerely hope that this long fight, will prove fruitful.

Sincerely,

EDWARD V. CURRY,
Councilman, 19th Senatorial District.

[From the Staten Island Advance, Jan. 5, 1971]

IT DOESN'T MAKE SENSE

Health, Education, and Welfare Secretary Elliot L. Richardson's administration isn't really as concerned about health care as it makes itself out to be.

If, as Mr. Richardson charges, the PHS hospitals are inefficient, that certainly is a recent development. Over the years, the big institution at Clifton has been a pioneer in many medical fields, including research, and its dedicated staff has won a number of outstanding awards.

Originally it was established in 1834 as the Seaman's Fund and Retreat Hospital, operated at first through a state head tax on merchant seamen, and later by voluntary contributions of ship owners and the Marine Society. The federal government took over its operation in 1903, and it was known as the U.S. Marine Hospital until 1951.

In addition to merchant seamen, it has provided care for Coast Guardsmen and their families, sick or injured immigrants, federal employes disabled on duty and quite a number of veterans.

To be sure, this nation's merchant fleet is a sad remnant of what it once was, and there has been a decline in seaman patients. But to shut down this hospital is unthinkable. Medicare patients alone would fill every bed, if policy were changed to permit their admission.

Secretary Richardson's comment that Veterans Administration hospitals could handle the patient load on a space-available basis is specious. The VA hospitals themselves have been the subject of much criticism for the very quality—inefficiency—which he says the PHS hospitals have.

With hospital beds and hospital staffs so short of the need, how can any conscientious official seriously consider shutting down an institution with such a proud history of service and so many hundreds of competent people on its staff?

Mayor Lindsay has directed Borough Development Director Holt Meyer and Leon Panetta of the mayor's staff, who also is an island resident, to confer with HEW officials in Washington Thursday to head off the closing, and instead to urge the federal government make the facility available to the total community.

Strangely enough, this move by a Republican administration is an echo of a similar proposal advanced during the last Republican administration—that of Dwight D. Eisenhower—by a commission headed by a former Republican President Herbert Hoover.

That commission's penny-wise, pound-foolish recommendation to shut the hospital down was rejected quickly. Is it possible that President Nixon, vice presi-

dent then, kept a copy of the discredited Hoover Commission proposal for all these years?

If the administration wants to effect economies, why doesn't it shut down some of the totally useless installations other government agencies retain? Such as the long-outmoded military posts in metropolitan areas which provide nothing more than a country club setting for pampered personnel?

(The following statements and letters were received for the record:)

STATEMENT OF AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is the professional organization of registered nurses in the United States. Its purposes are to foster high standards of nursing practice, promote the professional and educational advancement of nurses and promote the welfare of nurses to the end that all people may have better nursing care.

At this time, when there is an acknowledged health crisis because of the lack of qualified health personnel and adequate facilities for the care of people, the Association believes the proposed closing of the United States Public Health Service Hospitals and clinics may be short-sighted.

These facilities presently serve specifically defined groups such as merchant seamen, members of the Coast Guard and their dependents, dependents of members of the Armed Services, Public Health Service employees and Bureau of Employment Compensation patients. If this clientele seems too limited for the resources available, consideration should be given to extending the services to the people of the communities not now receiving adequate care in which the facilities are located. Expecting these communities, and other Federal installations, to assume the responsibility of providing care to those now cared for in the P.H.S. hospitals is unrealistic, given the shortage of health personnel and local public and private hospital beds and the understaffing and underfunding of other Federal health care facilities, especially in the health care system conducted by the Veterans Administration.

Further, the P.H.S. Hospitals and clinics are now contributing to the education of several types of health personnel. Many provide clinical experience for students of nursing, interns and residents, technicians and others. It would be difficult in some cases for the educational institution to find comparable clinical laboratories.

The hospitals have the reputation of being generous and responsive to community needs. Individuals, otherwise not eligible for care, have been admitted when the special research being conducted by the hospital staff would be of benefit. When an emergency arises which the local hospital cannot meet, admission is possible to the Public Health Service Hospital.

The American Nurses' Association is concerned that quality care be available to all who need it. Before the closing of facilities, public or private, in any community, careful planning should be undertaken to assure that comparable services will be available.

We would like to point out one example of community service. The Public Health Service Hospital is providing comprehensive medical services to the people of San Francisco and Northern California. While the major thrust of this hospital is directed towards the maritime industry, its facilities are used by the total community. A few examples follow:

(1) The San Francisco Community Hemo-Dialysis Unit provides treatment for acute and chronic renal disease. This unit as of January 20, 1971 was treating 12 patients, 3 Public Health Service beneficiaries, 3 V.A. beneficiaries and other patients from San Francisco and Northern California.

(2) The Leprosy Service and Leprosy Research Unit has at the present time 314 ambulatory patients and averages 5 in-patients; lectures are given at the University of California, Letterman General Hospital, Presbyterian Hospital and a large number of other Northern California hospitals; nearly 1,000 contacts of active leprosy patients are under surveillance by the Clinic.

(3) The Richmond Psychiatric Clinic and In-Patient Service provides mental health services for the residents of the Richmond District of San Francisco and in the six month period, July 1970 through December 1970, 144 out-patients evaluations and 398 treatment visits were performed for the Richmond District residents. The above three samples are but a few of the services that would be lost to the people of San Francisco and Northern California.

Another problem created by this proposed action would be the shortage of alternate facilities in the area. San Francisco's community facilities are now overburdened by the Medi-Cal cutbacks, and the additional demand of having to absorb the Public Health Service patients would be traumatic for both patients and staff.

Crews and passengers from passenger vessels, also, use this hospital.

As you can see, the American Nurses' Association has a vital interest in the continuing provision of these patient care services.

STATEMENT OF ROBERT W. NOLAN, NATIONAL EXECUTIVE SECRETARY, FLEET RESERVE ASSOCIATION

INTRODUCTION

Mr. Chairman and members of this distinguished Committee: I am Robert W. Nolan, the National Executive Secretary of the Fleet Reserve Association. The Fleet Reserve Association is a service organization composed of more than 82,000 career personnel of the United States Navy, Marine Corps and Coast Guard. Our membership comprises enlisted personnel and commissioned personnel who have prior enlisted service. Approximately fifty percent of our membership are serving on active duty. The remainder are in the Fleet Reserve components of the Navy and Marine Corps or are fully retired from these Services or the U.S. Coast Guard.

As a retired Chief Petty Officer of the U.S. Navy, I deem it a privilege to appear before you and present the views of my Shipmates on the issue of the possible future closing of thirty-eight medical facilities of the Public Health Service.

The F.R.A. has always maintained a vital interest in the matter of medical care for military personnel and their dependents. It was our Association that created the Congressional interest which initiated the House Armed Services Committee's investigation of the adequacy of medical care for military personnel in 1964. The investigation resulted in the passage of Public Law 89–614 in 1966. This law established the Civilian Health and Medical Program for the Uniformed Services. The program is known under the acronym, "CHAMPUS.

THE FLEET RESERVE ASSOCIATION'S POSITION

The Fleet Reserve Association supports House Concurrent Resolution Number Ninety-Eight. We oppose the closing or the transfer to other than Public Health Service control of the eight hospitals and thirty clinics of the Public Health Service. Our position is based upon:

the urgent medical needs of our nation,
the Public Health Service's expanding role in our nation's health plans,
the obvious false economy of the closures or transfers, and
the Department of Health, Education and Welfare's obligation to the beneficiaries of the PHS system.

THE URGENT MEDICAL NEEDS OF THE NATION

It is ridiculous to assume that the closure or transfer of these thirty-eight medical facilities will be in the best health interests of our nation. We are currently facing a health crisis in both medical facilities and trained personnel. To say that our endeavors to overcome that crisis would not be harmed by curtailing the Public Health Service's key role in the endeavors is foolhardy.

The key to the health crisis is trained personnel. We can find the money to build new medical facilities, but how do we staff them? The Public Health Service's role in training doctors is an outstandingly successful one. But we are not speaking only of professional medical men. We are also thinking of the PHS Hospital's Community Training Programs which train student nurses, nurses' aides, all types of therapy technicians, EKG technicians, X-Ray technicians, laboratory technicians, pharmacy assistants, dental technicians, dietary aides, medical facilities will be in the best health interests of our nation. We are programs can ill afford to lose this source of trained personnel.

THE PUBLIC HEALTH SERVICE'S EXPANDING ROLE

Under the Emergency Health Act of 1970 the role of the Public Health Service has been greatly expanded. This expansion includes a program of medical care for the underprivileged. It seems to us ludicrous for Congress to enact such a law and at the same time have the Administration act to abolish the very medical facilities that are to provide the medical care! What should be taking place is a collective effort by the Administration and the Congress to improve and modernize those PHS facilities that require it and to be realistic in the budget requirements of the Public Health Service in view of its new responsibilities.

THE OBVIOUS FALSE ECONOMY OF CLOSURES OR TRANSFERS

To assume that the closing of the thirty-eight Public Health Service medical facilities or their transfer to non-Federal government operation will result in financial savings for the government is the height of naivete.

The statutes charge the Public Health Service with the responsibility of providing medical care to merchant seamen, U.S. Coast Guard personnel and their dependents, Public Health Service Corps personnel and their dependents and military personnel (active duty and retired) and their dependents. These groups total approximately two million patients and they are growing! To provide medical care for them at the ever-rising costs of medical care in non-Federal government facilities is certain to at least double the cost to the government.

If the plan to transfer these medical facilities to private enterprise is concluded, the Federal government's cost will not cease. The Department of Health, Education and Welfare witnesses have testified that some of the facilities require modernization. Such modernization would be accomplished under the provisions of the Hill-Burton Act. Thus, the Federal government would still assume a good portion of the modernization costs!

Another false economy factor is the effect the closing or transfers would have on the nation's economy and unemployment. We speak not only of the jobs lost by those directly employed in the Public Health Service, but of the thousands who are trained and subsequently employed in the medical field and the thousands of employees who earn their livelihood in association with these medical facilities. Needless to say, the closing of these facilities would have far reaching effects on the nation's economy.

THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE'S OBLIGATION

The Department of Health, Education and Welfare under law has an obligation to the two million beneficiaries of the Public Health Service system. In the Department's testimony to date we have heard nothing that assures us they are aware of this obligation and intend to live up to it in the future.

For example, in speaking of transferring the hospitals to private authority, they propose that Public Health Service beneficiaries will receive their care in those facilities at government expense. But how do they intend to guarantee that a bed will be available to that patient? We doubt that such guarantees can be given in today's era of severe hospital bed shortages in almost every community. Even under the best guarantee the occasion would arise where the PHS beneficiary has no bed available to him.

We find the Department witnesses' stressing of the division between "primary" and "secondary" beneficiaries distressing. As dedicated medical men, they should not make such divisions, but instead devise ways to assure maximum care for all in accordance with their Hippocratic oath.

We wonder if they realize that the drop in the number of their primary beneficiaries is in direct ratio to our nation's declining maritime strength? Are they also aware that this strength is being rebuilt and in the future there will be an increased need for medical care of merchant seamen?

While it is true that the "secondary" beneficiaries of the Public Health Service may receive medical care under the provisions of Public Law 89-614, if all such beneficiaries were to avail themselves of such care, it would dramatically increase the government's medical costs unnecessarily.

THE FINANCIAL PLIGHT OF AGED MILITARY RETIREES

To many aged military retirees and their wives living in areas where there are no military medical facilities, the Public Health Service medical facility is their "family doctor." These are the people who have devoted the major portion of

their adult lives to the service of their country in hopes of assuring themselves that they would gain a self-sufficient measure of financial security and not be a burden to their families. The irony of their unwarranted fate is that because of factors beyond their control they find themselves destitute today. The promises they received of equitable annuities and earned benefits are faded and broken by an employer who can no longer afford to maintain the principle of recomputation of retired pay. The inflation spiral of the last decade has diminished the purchasing power of their retirement income. They find that their fixed retirement income does not begin to afford them the bare necessities of life, let alone any small personal luxuries.

While their medical care may not be a major factor in the eyes of some, it most assuredly is a key factor in this issue! To deny these faithful employees adequate medical care in Public Health Service medical facilities is a shameful and heartless act.

Therefore, keeping in mind the role given to the Public Health Service under the Emergency Health Act of 1970, we ask that this Committee assure that the primary and secondary beneficiaries maintain their priority for receipt of care if new classes of beneficiaries are authorized care in Public Health Service medical facilities.

CONCLUSION

Mr. Chairman, it has been our pleasure to appear before you today. We appreciate the opportunity to exercise this franchise of our democratic form of government. It is because we dearly love and wish to preserve that franchise that we chose to serve our nation as career professional service personnel. We thank you.

STATEMENT OF THE GOVERNMENT EMPLOYES COUNCIL, AFL–CIO

Mr. Chairman and members of the Subcommittee: As a coordinating organization for 34 AFL–CIO unions representing in excess of 1 million Federal employes, we appreciate your arranging hearings on the future of Public Health Service facilities and the opportunity afforded the Council to offer its views.

Our unions are deeply concerned about the anuounced plan of the Executive Branch to close eight remaining Public Health Service hospitals and outpatient clinics throughout the country.

This keen apprehension centers around four points.

First, as an organization representing the interests of Federal workers as citizens, we are troubled by any attempt to terminate or transfer from Federal jurisdiction those vital functions performed by PHS for almost a hundred and seventy-five years.

Second, some of the unions associated with the Council represent merchant seamen, the primary beneficiaries of PHS care.

Third, as a Council representing Federal workers, we must express concern over the loss of service supplied by PHS to these employes who incur job related injuries.

Fourth, among the unions affiliated with the Council are those who have civilian employes of PHS activities as members.

Whether the present plan of the Executive Branch is to discontinue operation of all PHS hospitals and clinics simultaneously or to accomplish that goal piecemeal, the central issue is the same.

It is an accepted fact that our nation is confronted with a crisis in meeting the health care needs of its people. Congress has and continues to address itself to this problem. Even now, committees of the House and Senate are concentrating attention on the inadequacy of present health facilities, treatment, and spiraling costs of medical care. To even contemplate closing existing PHS institutions under these conditions is a disservice to millions of Americans, who must wait weeks to secure needed hospital and surgical assistance.

Marine hospitals were first established in 1798 to extend health services to American seamen using American ports. While tradition alone should not be the sole justification for continuing the existing PHS system for these workers, it is unthinkable that merchant mariners would be tossed into the maelstorm of confused and inadequate health services existing in other spheres of our society at the present time. And this is exactly what would happen if one or more of the present PHS facilities is discontinued.

This Subcommittee is aware of the steady erosion of PHS facilities which has occurred over the past twenty-five years. Even with the continuing expansion of health problems throughout the nation, PHS hospitals have been closed.

Yet, in 1970, Congress approved a new Merchant Marine Act designed to move the United States again into the mainstream of maritime nations by expanding our merchant fleet. Presumably, construction of additional vessels will result in employment of larger numbers of merchant seamen. It is foolhardy to plan reductions in health services for maritime workers at a time when the demand for these functions will increase.

Other witnesses have acquainted you with the cost of patient care in PHS hospitals compared with similar service in private facilities and the folly of shifting the PHS patient load to non-Federal communities already overburdened with health and financial problems.

We have not dealt with the legal question of the right of the Department of Health, Education and Welfare to proceed with its plan, because the record is clear on this point through a decision by the Comptroller General. The basic question is whether the Executive Branch can in good conscience proceed with its plan for terminating PHS facilities in the face of the health crisis in our country.

Members of this Subcommittee are aware that Federal employes injured on the job are able to receive diagnostic services and treatment at PHS facilities under authority of the Federal Employees' Compensation Act, when available. In general, the quality of this assistance has been superior.

In a normal year, more than 100,000 Federal civilian employes experience job related disabilities. We do not know how many of these persons require PHS care. But reduction or termination of PHS operations would deprive injured Federal workers of this inexpensive, high quality medical care.

It has been suggested that these activities of PHS could be transferred to Veterans Administration or private institution. This proposal ignores the facts. VA hospitals have a primary mission of assisting veterans. They are overcrowded and understaffed. The same is true of private facilities. To insist that Federal employes be referred to these other institutions will mean simply that they will not receive the timely, expert medical service to which they are entitled.

Finally, the Subcommittee should consider the equity of more than 6,000 civilian employes of PHS. None of the public pronouncements of the Department of Health, Education and Welfare have alluded to the future of these Federal workers. Most have devoted their careers to the humanitarian goals of PHS. Many are in age categories that would make it difficult for them to find suitable employment elsewhere, despite the shortage of paramedical and professional skills in the labor market. This is certainly no time for the Federal Government to think of adding to the serious unemployment level in our country.

The anxiety stimulated by the uncertainty of job security is causing a serious morale problem among the employes. Nothing has been said to reassure them about plans for utilizing their skills elsewhere in Federal Service.

We urge, Mr. Chairman, that the Subcommittee move expeditiously to approve the pending resolution, and hope sincerely that the Executive Branch will heed any expression by Congress on the matter.

The Council is grateful for this occasion to acquaint you with the seriousness of the action proposed by the Administration.

STATEMENT OF HERALD E. STRINGER, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Subcommittee: The American Legion welcomes the opportunity to express its views on the proposal of the Department of Health, Education and Welfare to close eight Public Health Service general Hospitals and 30 outpatient treatment clinics.

Our interest and concern in this proposal, apparently emanating from the Office of Management and Budget, relates not only to the responsibility of the United States Public Health Service hospital and outpatient facilities for members of the Armed Services, active or retired (Army, Navy, Air Force, Marine Corps, and Coast Guard); the commissioned corps, active or retired, of the Public Health Service and the National Oceanic and Atmospheric Administration and their dependents; dependents of deceased active duty and retired mem-

bers; American merchant seamen; employees on the vessels of the Mississippi River Commission and of the Fish and Wildlife Service; Civil Service employees injured on the job; and foreign merchant seamen on a bed available basis—but also to the effect of shifting of some of the burden of the care and treatment of these beneficiaries to an already overtaxed Veterans Administration medical and hospital care service.

In advancing this proposal, the Office of Management and Budget continues the plan initiated in 1965 to close seven of the then existing twelve Public Health Service hospitals with the explanation that arrangements had been made between the Veterans Administration and the Department of Health, Education, and Welfare to cross-service certain patients and—at the same time—advanced the proposal to close eleven Veterans Administration hospitals.

Again in 1971 we have a similar pattern of proposals—close the remaining eight Public Health Service hospitals and outpatient clinics serving the beneficiaries enumerated earlier, shift some responsibility for their care to the Veterans Administration through cross-servicing, and reduce the number of active beds in Veterans Administration hospitals (according to the proposed medical care budget for fiscal year 1972, the average daily census in VA hospitals will be reduced by approximately 5500 patients, to a level of 79,000).

Our analysis of the potential of 28 million veterans in civilian life and the planned average daily patient census in Veterans Administration hospitals fails to comprehend any merit in the proposal from the standpoint of reduced cost or improved service to PHS or VA beneficiaries. We believe that an agreement to cross-service any part of these beneficiaries in VA facilities on a continuing arrangement cannot but seriously impair the ability of the Veterans Administration to effect its mission of providing quality medical and hospital care to eligible veterans for nonservice-connected disabilities.

Apparently, under the cross-servicing agreement contemplated, Public Health Service beneficiaries would be given a priority for admission to VA hospitals immediately after service-connected veterans but ahead of eligible veterans seeking care for nonservice-connected conditions.

In our appearance before this Committee in 1965 on the then proposed closure of Public Health Service hospitals, we questioned the citation of 31 USC 686 by the Veterans Administration as authority for cross-servicing agreements with the Department of Health, Education and Welfare to hospitalize nonveterans in VA hospitals on a continuing basis. As you know, our views on this were sustained by the Comptroller General's Decision, which said in part—

"The use of section 686 would require the Veterans Administration to be in a position to supply or equipped to render the requested services. * * * and we are of the opinion that the situation of being in a position to render service cannot be artificially created by the promulgation of an administrative regulation, under 38 USC 621, which would subordinate statutory beneficiaries of the Veterans Administration to beneficiaries of other agencies and constitute a relinquishment of the Veterans Administration's primary responsibility."

Aside from the issue of whether the Secretary of Health, Education and Welfare has the authority to close these United States Public Health Service facilities and to arrange for treatment of these beneficiaries under continuing contract in community facilities and cross-servicing agreements with the Veterans Administration and other federal agencies, we believe that the decision is ill-advised. It comes at a time when health care services in the United States appear to be at a critical low—when every effort should be made to expand health services as well as facilities in which to train needed medical and other allied health personnel.

This proposal, we believe, is in total conflict with President Nixon's National Health Strategy as outlined in his message to the Congress on February 18, 1971. A part of his comprehensive health policy for the Seventies is meeting the special needs of scarcity by supporting outpatient clinics and health education centers in areas which are underserved.

As the Committee knows, most Public Health Service facilities are strategically located in ghetto neighborhoods and they can become deeply involved in providing scarce medical services to low income groups, and Public Health Service hospitals are deeply involved in the production of badly needed health service personnel as well as in research.

With respect to the springboard for the proposal—that the hospital buildings date back to the Thirties, that they are in need of modernization—a statement of an expert at Johns Hopkins University, Dr. Charles Flagle, indicates that 80 percent of the nation's hospitals are as old or older.

For the foregoing reasons, Mr. Chairman, The American Legion urges the continued operation of these United States Public Health Service hospitals and clinics, and that legislation be enacted restoring needed funds to the fiscal year 1972 Department of Health, Education and Welfare budget for their continued operation and modernization.

Thank you for this opportunity to express our views on this perplexing proposal.

STATEMENT OF EDWARD DAVENS, M.D., REPRESENTING THE REGIONAL MEDICAL PROGRAM OF MARYLAND

Concerning proposed closing of Public Health Service Hospitals. Mr. Chairman and members of the Committee, my name is Dr. Edward Davens, Coordinator of the Regional Medical Program of Maryland whose goal is to improve the quality and distribution of health care in the Maryland region for major chronic diseases and more recently to assist in implementing a national health maintenance strategy.

In this latter connection, I want to tell you how impressed I am with the extensive and successful plans under Public Health Service Hospital leadership to develop a Health Maintenance Organization to serve the Montebello-Homestead neighborhood which surrounds the hospital and which is virtually without primary health care services. The community is very well organized and is enthusiastic about the plans which have been made. Also, the Baltimore Areawide Comprehensive Health Planning Ageney ("B" Ageney) which is part of our Regional Planning Council for Metropolitan Baltimore is very enthusiastic.

As you are well aware, President Nixon in his Health Message to the Congress on February 18, 1971 strongly emphasized a modification of the health care delivery system by promoting the development of Health Maintenance Organizations which he went on to define. Secretary Richardson, in his testimony before Senator Kennedy's Health Subcommittee, also made major reference to this as part of a new national health maintenance strategy.

The painstaking planning efforts that have already taken place around the PHS Hospital in Baltimore are right on target with the new national health strategy. A working partnership between the community and the hospital has already been forged. Experience elsewhere has shown that this is half the battle, and it is for this reason, as well as the desperate need for health care in that section of Baltimore, that I believe that the department of Health, Education and Welfare has at its disposal an ideal laboratory for an experimental health services planning and delivery system. Another plus is the existing scientific epidemiological and careful investigative orientation of the medical leaders there. This will be a big help in careful and objective evaluation of how best to launch an HMO. After the demonstration is launched and tested, it could then be transferred for continued management and responsibility to an appropriate community agency.

It seems to me that the situation presents a really superb opportunity for the Department of Health, Education and Welfare to support a creative effort to establish, study and evaluate a Health Maintenance Organization to support the recently announced Administration policy. Ultimately, when well established and successful, the operation could be transferred to local management in accordance with plans being developed by groups such as the Areawide Comprehensive Health Planning Agency.

It is for these positive reasons that I would urge that the opportunity presented in this situation not be lost by peremptory closing and scattering of the smoothly functioning organization of health professionals and related personnel (and not the buildings) which *is* the Baltimore Public Health Service Hospital.

STATEMENT OF JOSEPH M. WHITE, M.D., VICE PRESIDENT FOR ACADEMIC AFFAIRS AND DEAN OF MEDICINE, THE UNIVERSITY OF TEXAS MEDICAL BRANCH, GALVESTON, TEX.

Mr. Chairmau and Members of the Committee: The University of Texas Medical Branch and the U.S. Public Health Service Hospital at Galveston have complementary goals. These goals are essential to both institutions and contribute to both local and national needs. The PHS hospital, through its medical

care responsibilities and its intramural training programs, is a resource to the University for its primary and expanding responsibilities in medical education and research. The University's programs, through affiliated and integrated programs with the PHS hospital, broaden the scope of services which can be provided to Public Health Service beneficiaries and foster excellence in patient care and training.

The Department of Health, Education, and Welfare has proposed that the present PHS hospital and its programs be placed under the management of a community organization or institution in order to increase its responsiveness to community needs and to enlarge on other potential sources of support for its operation. The Department has said: (1) it would continue to support the costs of the services presently provided to its beneficiaries, (2) during a period of transition, PHS personnel would be provided, (3) special programs or services would continue in operation, and (4) as a private institution, the hospital would be eligible to receive third party reimbursements for services rendered to other than primary beneficiaries and would be eligible for facility funds under existing Federal programs.

Based on the conditions stated by DHEW, the potential does exist in Galveston for the development of such a private-Federal partnership, and the University of Texas Medical Branch would be interested in exploring various alternatives in conjunction with local community health agencies and organizations. However, because of the intricate legal, administrative and financial questions involved, it appears that several months would be required for planning before a final opinion could be offered on the Department's proposal.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., February 28, 1971.

Mr. W. E. WILLIAMSON,
Clerk, Interstate and Foreign Commerce Committee,
Washington, D.C.

DEAR MR. WILLIAMSON: I was wondering if I might submit for the hearings of the Public Health and Welfare Subcommittee the letter of Dr. Stephen Kollins, who is Acting Chief Medical Officer of the Cleveland Public Health Service Outpatient Clinic. In it he describes the work of the Cleveland Clinic, as well as makes some thoughtful suggestions for the future of the program.

Thank you for your cooperation.

Sincerely,

JAMES V. STANTON, *Member of Congress.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Cleveland, Ohio, January 22, 1971.

Hon. JAMES D. STANTON,
The House of Representatives,
Washington, D.C.

SIR: We are aware that as Congress convenes this month, you will be considering the *Administration's proposal to close down the U.S. Public Health Service hospitals and clinics.* With this in mind, I would like to acquaint you with some pertinent facts about the *Cleveland Public Health Service Outpatient Clinic.*

[Our clinic here, as other Public Health Service Clinics, takes care primarily of Coast Guard personnel, their dependents, and seamen in the Merchant Marine. In addition, we regularly examine persons eligible for employment compensation and disability retirement for the Post Office and other Government agencies. Almost daily we examine FBI personnel, either for annual physical examinations, or for applications to the FBI Service. We examine retired military personnel in all services, care for the dental health of these patients as well, and recently have been providing regular care for Vista personnel stationed in Cleveland. We also do annual examinations for the Department of Defense in their executive department, and entrance examinations for candidates to the Peace Corps, State Department Foreign Service, Vista, and the Public Health Service itself. Our clinic here in Cleveland is the regional yellow fever center, and weekly we see from fifteen to fifty patients who obtain their yellow fever vaccine here.]

Our total annual census, including the dental clinic, was approximately 18,000

visits for the fiscal year 1969. For these patients we provide full medical care, including medications, diagnostic studies, basic clinical pathology, and complete radiographic studies, including gastrointestinal contrast examinations and intravenous pyelograms.

We have readily available to our clinic, and make regular use of consultants in radiography, internal medicine, neurology, otolaryngology, ophthalmology, gynecology, dermatology, psychiatry, and allergy.

Our annual budget for 1969 was less than $194,000, approximately less than $11 a patient visit for what we considered complete care. It is hard for me to imagine physicians elsewhere in this community providing such complete diagnostic and therapeutic services for anywhere near that price. The most distressing fact related to the possible closing of the clinic is the criticism that we are outmoded, inefficient, and UNDERUTILIZED. Although the clinic walls could use a painting, *we are NOT outmoded and NOT inefficient.* Certainly we are not seeing the number of patients we have seen in prior years, but it is my feeling this reflects, in part, the availability of other federally-funded health care services i.e. Medicare. We are, however, running an active clinic which requires the presence of two full time physicians and one part time physician, three nurses, two dentists, and two dental assistants.

Equally as distressing is the recent publicity given to the Bill HR–19860, signed by President Nixon, which has granted $60,000,000 to the Public Health Service to utilize commissioned officers such as myself in ghetto areas of cities such as Cleveland. Our clinic, although not located in a ghetto area, is located in the heart of metropolitan Cleveland. *We are less than one hundred yards from the hub of all public transportation in Cleveland, making us more readily accessible to all segments of the population than any other clinic facility in this city,* and certainly more accessible than the difficult-to-reach Veterans Administration Hospital and Outpatient Clinic, which is postulated to take over care of our patients.

I think Senators Magnuson and Jackson of Washington, D.C. have authored and sponsored a fine piece of legislation. However, replacement of this clinic with physicians sponsored by their bill would be a definite unnecessary expense to the Government. Transferring our patients to the Veterans Administration Hospital for their care and providing Public Health physicians and dentists for ghetto areas here in Cleveland would be an unnecessary duplication of services. *We have at least 1,500 square feet of unused floor space immediately available for expansion into examination or treatment rooms within the clinic as it exists today.*

I have not practiced medicine at the Cleveland Veterans Administration Hospital, but I have had several opportunities to visit their already-crowded emergency room and outpatient clinic, and I don't believe they can conveniently see the 1,500 or more patients per month we see here in our clinic now. Expansion to handle the needs there could equally be matched by expansion here in our centrally-located clinic at equal, if not less, cost to the Government. It is my feeling that we should continue to care for the patients we are now seeing, and that a modest increase in our facility would most efficiently and most conveniently handle *some* of the needs of Cleveland's ghetto population. I believe our clinic is needed *where* it is, and if expanded to handle a larger patient (? ghetto) population, could provide the *comprehensive continuing care* which is needed in this city and country at this time.

Very truly yours,

STEPHEN A. KOLLINS, M.D.,
Surgeon—Acting Chief Medical Officer.

BALTIMORE CITY HEALTH DEPARTMENT,
Baltimore, Md., March, 5, 1971.

Re USPHS Hospital, Baltimore, Md.

Mr. W. E. WILLIAMSON,
Chief Clerk, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. WILLIAMSON: The Baltimore City Health Department wishes to have placed in the records of the hearings on the future of the USPHS Hospital (Baltimore), now being held by the Subcommittee on Health and Welfare of the House of Representatives, the following statement:

Closure of the USPHS Hospital (Baltimore) will work a large and needless hardship upon the people of this city and upon the medical and health facilities which support them. The Health Department is fully aware of the many and

divers services rendered by the USPHS Hospital in fields like research, training of several levels of health personnel, inpatient services for acute and chronic disease conditions, outpatient services to a large population of patients, and innovative services such as multiphasic screening.

The Health department believes that all of these necessary services cannot be assumed by existing public and private agencies without hardship or needless extravagance. Neither existing budgets nor structures, let alone manpower, can be quickly adapted to fill a void which will result if the USPHS Hospital is closed in the unwise and unplanned manner now proposed.

The citizens of Baltimore speak strongly and with good reason about the hidden or latent racism which this action is believed to have revealed in high placed administrators. Just as the Hospital was about to extend its service outreach to a large, non-doctored Negro community at the request of this Department, and just as Congress had authorized placement of USPHS medical officers in needy areas, the Administration announces its poor decision to close down all USPHS Hospitals. It does not matter that such a belief regarding racist attitudes or discrimination against the needs of our urban Negro population has been ignored by the leaders in HEW and higher, for it is still true that it exists. It is also true that, for the time being, it must be faced by urban governments. However, it should be carefully noted by all levels of government that cities and their agencies find this intolerable situation created by management-at-a-distance increasingly distasteful.

The Health Department of Baltimore recommends that reasonable and prompt decisions concerning the future of USPHS Hospital (Baltimore) be made only after having gone through the planning process made into law by the Federal Government (Partnership in Health) and conducted by the Regional Health Planning Council for Metropolitan Baltimore; that these planning processes include health representatives from the City of Baltimore; that these discussions include or be based upon the concept that the USPHS effort will be continued unabated for several years, until a suitable local response can be developed to assume this responsibility; that the USPHS begin here to develop new outreaches in ambulatory patient care which are now either ready for funding or in need of experiment; and that similar actions be taken in the case of the other several USPHS Hospitals in the United States.

Sincerely yours,

JOHN B. DE HOFF, M.D.,
Deputy Commissioner.

NEW ORLEANS, LA., *March 19, 1971.*

W. E. WILLIAMSON,
Clerk, Congress of the United States,
House of Representatives, Washington, D.C.

DEAR SIR: Thank you very much for your prompt response in relation to the material which I sent you on the closing of the Public Health Service Hospital. For the printed record, I prefer that you insert my letter of January 29, 1971 to The Honorable Elliott L. Richardson and a copy of my statement of January 18, 1971 which has been adopted as the official Council position on this matter.

This letter calls upon the Secretary to utilize the areawide health planning agencies created under Public Law 89-749 in his study of the hospitals and is in this regards consistent with H. Con. Res. 98, et al. in its call for local study of each of the Public Health Service Hospitals.

With kindest personal regards, I remain,

THOMAS J. LUPO, *President.*

Enclosures.

NEW ORLEANS AREA/HEALTH PLANNING COUNCIL,
NEW ORLEANS, LA., *January 29, 1971.*

Hon. ELLIOTT L. RICHARDSON,
Secretary, U.S. Department of Health, Education, and Welfare,
Washington, D.C.

MY DEAR SIR: According to an article which appeared in the New Orleans States-Item on January 25, 1971, your office has "never contemplated shutting down Public Health Service Hospitals." (A copy of this article is enclosed.) This is indeed encouraging news, if accurately reported. I also noted that the Public Health Service Hospitals, including the one in New Orleans, are to be studied to find "alternative uses."

In behalf of the New Orleans Area Health Planning Council, which I represent, I would very much appreciate your advising this Federally recognized health planning agency of the who, when, and where of this study. We certainly hope that you do not consider the "opinion gathering team" headed by Dr. Shinnick which visited our city last week as a study team to determine alternative uses for our PHS Hospital.

If it is your desire to determine the best use this community can make of the hospital, I urge you to follow the recommendations included in my telegram of January 18th in which I suggested that you allow the areawide health planning agency to participate, as it should, in this decision. You have not as yet responded to the telegram or the suggestion; therefore, I am officially requesting your office to take the following action:

1. Authorize the NOAHPC to undertake a formal study, to be completed within ninety days, to determine the appropriate role of the U.S. Public Health Service Hospital in this community.
2. Authorize the NOAHPC to enter into agreements with mutually acceptable unbiased, qualified consultants to properly perform the study.
3. Authorize Public Health Service personnel assigned to Region VI to assist in the development of a project application to support the study.
4. Authorize the appropriation of approximately $75,000.00 as a grant to the NOAHPC to fund the study.

Only in this manner can we determine the appropriate future role of the hospital in New Orleans. One reason for the creation of areawide health planning agencies was the recognized necessity to bring planning to the people in the people's community. The appropriate role for the PHS Hospital in New Orleans might not be appropriate for the hospital in San Francisco, Baltimore, or elsewhere. If it is, then there is no need for areawide comprehensive health planning.

We are hopeful that you can appreciate the wisdom of providing the funds for us to conduct the three month study in New Orleans. Recognizing our mutual interests in reaching a solution to this difficult decision, I offer you the full support and cooperation of the NOAHPC. Should you have any questions concerning my proposals, please call me at (504) 525-6237 or (504) 486-3773.

With kindest personal regards, and anticipating your response as promptly as conveniently possible, I remain

THOMAS J. LUPO, *President.*

Enclosures.

[From the Times-Picayune, Jan. 26, 1971]

(By Ashton Phelps)

'BACKTRACK' ON PHS HOSPITAL

After more than a month of furor over the proposed closing of the United States Public Health Service Hospital in New Orleans and those in six other cities, Secretary of Health, Education and Welfare Elliot Richardson has suddenly announced that his office "never contemplated shutting down PHS hospitals."

On Dec. 29, Mr. Richardson told a House Merchant Marine Committee hearing that the majority of PHS hospitals were "under-utilized, inefficient," etc., and when asked whether closing them was the best answer, considering the health services "delivery" crisis, he answered, "It can be argued that closing these hospitals will bring more efficient distribution of health professionals."

The final decision on the closings would be made, he said, before President Nixon presents his budget to Congress in January.

The plan to close the hospitals and 30 clinics nationwide was revealed in mid-December by Rep. Paul Rogers (D-Fla.), and the outcry—from high-level state and local representatives whose voices are heard in key places—grew until HEW decided to send a fact-finding team to the affected cities.

It arrived her Jan. 18 and came under immediate attack by *one local consultant as an attempt to "rationalize a decision that's already been made."*

Now Secretary Richardson, speaking to the Louisiana School Boards Association in Shreveport, politically backtracks, saying it was not a matter of "closing" but of studying "alternatives uses" to implement the law passed last year prescribing expansion of the PHS into a doctor corps caring for a wider public than that traditionally authorized.

But even that is only a suggestion, not a concrete program at this time, and a study of the hospitals will be released later, but he does not know exactly when.

The issue is not thereby really resolved—but it seems that it could well have

been resolved by the closings obviously originally planned on, if the alarm had not been sounded and forcefully responded to by those leaders whose job is to look out for the community's overall welfare. The public owes them thanks.

* * *

HOSPITAL SHUTDOWN RULED OUT

(By Danny Greene)

SHREVEPORT.—The Secretary of Health, Education and Welfare said today that his office "never contemplated shutting down Public Health Service hospitals."

Elliott Richardson made the statement at a press conference prior to addressing the Louisiana School Boards Association, which is holding its 34th annual convention here.

Richardson said the eight Public Health Service hospitals, including the one in New Orleans, are being studied to find "alternative uses."

Richardson suggested that Public Health Service hospitals could enter contractual lease agreements with the cities in which they are located to provide health care to a larger segment of the population. Public Health Service hospitals largely serve persons in federal service and their dependents, veterans, drug addicts, seamen and Coast Guardsmen.

Richardson said his office is attempting to determine whether it is feasible to serve a "narrowly defined group."

He said if the facility were to be converted into something like an out-patient clinic, a greater segment of the population would be provided health care without great additional capital outlay.

He said under a program like this, the federal government could reimburse the hospital for health care provided to federal government employes and other federal public service workers.

Richardson said this is only a suggestion and not a concrete program at this time. He said a study made of each of the eight hospitals in question would be released at a later date, but that he doesn't know exactly when.

The HEW secretary avoided giving specific details of last night's meeting with the President's Advisory Committee on Desegregation for Louisiana.

He did say, however, that the discussion "focused on needs of education for all children regardless of race."

He said he was impressed by the cooperative spirit of the group and that "nobody was arguing about what the law says. It was a matter of 'what do we do now?' in the interest of quality education." He said advisory committees in all Southern states have shown the same spirit of cooperation.

Richardson said the Nixon administration feels that the South has made "extraordinary progress" in school desegregation.

"Those who predicted widespread violence were frustrated by the high degree of cooperation from people in the South."

He said there still are some problems, mainly in the area of dismissals of black teachers and principals, but that he believes the problems all are solvable.

Richardson told LSBA delegates that in the South last fall, there was no major coercive effort by the federal government. "Instead, there was an effort on the part of individuals and the local community to abide by the law."

Richardson told the group one of the most complex problems in desegregation efforts is the matter of "ability grouping and tracking" in the classroom.

Ability grouping and tracking are educational devices designed to provide extra assistance to both slow learners and fast learners by placing them in classes where all the students have approximately the same learning rate.

Richardson said this device sometimes is abused, and that instead of a beneficial educational device, it becomes an instrument for segregation. He said, however, that ability grouping is an accepted instructional method and should not be changed unless it becomes a tool for racial separation.

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NEW ORLEANS AREA HEALTH PLANNING COUNCIL,
New Orleans, La., January 19, 1971.

To: New Orleans Area Health Planning Council & its Participants.
From: Thomas J. Lupo, President.
Subject: New Orleans Public Health Service Hospital (statement by Thomas J. Lupo).

Attached you will find a documentary on the posture I have had to take in the matter of the Public Health Service Hospital Task Force meetings being

held in the city. I first learned of these meetings on Friday evening and on Saturday and Sunday I contacted many of our Board members to get the benefit of their counsel and advice as to the best method of handling this matter. Although I could not contact our entire membership, there was a concensus among those with whom I consulted that this matter was of such vital import to the health delivery system that there was little alternative to do anything else.

Trusting that my handling of this will receive your usual kind consideration, I remain

Respectfully

THOMAS J. LUPO.

Enclosures.

STATEMENT OF THOMAS J. LUPO, PRESIDENT, NEW ORLEANS AREA HEALTH PLANNING COUNCIL

I have refused to participate in today's meeting and am obligated to share with you my reasons for my decision.

The New Orleans Area Health Planning Council has a long standing policy that all of its meetings, including committees and board, are always open to the public and the representatives of the communications media.

Further, as many of you may know, for over 26 years of involvement in planning, I have held firm to the principle that "closed" meetings on matters of vital concern to the public are not in the best interest of the public. As a consequence, I have consistently followed a policy of not participating in closed meetings. I firmly believe that there is no room for starcourt technique in this America.

The statement I hand to you is the statement I would have given to the task force, had the meeting been open to the public and the press.

Approximately 10 days ago I issued a statement regarding the proposed closing of the U.S. Public Health Service Hospitals.

In it I pointed out the several compelling reasons why this proposed action, unilaterally taken by the Secretary of DHEW was contrary to the public interest and a denial of the Federal Government's responsibilities to local communities as fully participating members in the comprehensive health planning process. (A copy of this statement is attached.)

It is still my considered opinion that this unilateral decision was a serious mistake in judgment on the part of the Secretary.

Today's attempt by Secretary Richardson to establish the "illusion of community involvement" by use of a hurriedly appointed staff task force meeting with selected groups in our community further compounds the Secretary's judgmental error.

The facts are as follows

1. The series of proposed meetings scheduled to begin today (Monday) were called late this past Friday afternoon. Such hastily summoned hearings confront us with a virtual *fait-accompli*.

2. On Saturday night, a few of us had our first opportunity to view the series of questions the task force members are expected to present to those invited to participate. In my personal judgment, these questions are not designed to explore the important issue of whether the hospital should be closed or not, but rather are carefully worded to solicit answers regarding how the community will absorb the additional load imposed on it *"when* the hospital is closed".

3. The individuals asked to meet with the task force, on this short notice, although almost without exception already participate in the New Orleans Area Health Planning Council's program, are nowhere near to representing all of those areas of concern who are members of our Council and who deserve to be heard on a matter of such vital import to the health profile of this area.

This action by the Secretary ignores every principle of sound planning and community participation inherent in our area health planning progams. I am compelled to interpret his action as an overt attempt to circumvent today's recognized planning process, to deny the communities effective participation in a matter of vital import to all its citizens, and further, it is contrary to the express wishes and intent of the Congress of the United States as clearly set forth in the comprehensive health planning legislation.

By way of background, allow me to point out that the New Orleans Area Health Planning Council, which I have the honor and privilege to serve as

President, is *the* single agency in Southeastern Louisiana recognized, approved and funded for comprehensive health planning by the Department of Health, Education and Welfare, under the provisions of the Comprehensive Health Planning Act (P.L. 89–749), and NOAHPC is *the* recognized agency for this purpose by the Louisiana State Interdepartmeutal Health Policy Commission (The State agency for health planning), further, NOAHPC is the recognized agency for purposes of technical review and comment on all Federally funded health programs for which the Intergovernmental Relations Commission of the State of Louisiana and the Regional Planning Commission are responsible in performing a clearinghouse function under provisions of Bureau of the Budget Circular A–95. The Council has been carefully structured to truly represent the demographic, geographic, and ethnic complexion of its area of concern.

Charged with this responsibility our Council has carefully prepared procedures for the review of all health programs in our area that involve the use of Federal funds, and relies upon carefully chosen professional and community representatives working through a series of technical committees and well established decision making bodies of our community. Among the more than three hundred individuals actively participating in the Council program are individuals representing all of the agencies participating in this series of meetings with the Public Health Service Task Force today.

The Council also maintains a highly competent paid technical staff to perform the necessary research and documentary to adequately support the planning functions essential to the community health planning process.

This current attempt by a DHEW staff "task force" to "review" the Secretary's decision with local community leaders is an insult to the intelligence of these leaders, as well as an insult to the integrity of the U.S. Congress. To assume that the demands of sound community planning can be served through such a series of informal, hastily summoned conversations with a selected few members of our community is absurd.

It would be a tragic mistake for us to delude ourselves into thinking that the best interests of our community can be served through an abortive attempt to reach mature planning decisions through an inadequate effort such as this.

The New Orleans Area Health Planning Council has no desire or intent to debate the issues relative to the closing of the Public Health Service Hospital under the "bureaucratic panic-planning process" arranged for today by Secretary Richardson's staff. Rather, we address ourselves to a question of principle. That principle is the Federal Government's obligations to adhere to its responsibilities as an equal partner with our local community in the concept of partnership for health, a mechanism created by the Congress and activated by the President of the United States. Further, as a matter of principle, I personally feel strongly that the Secretary is obligated to adhere to the dictates of Congress as set forth in the legislation.

We respectfully suggest an alternate course for the Secretary to follow. This course would include the following:

1. Acknowledge the Federal Government's responsibilities for adherence to sound planning principles and community participation.

2. Defer any decision on the question of closing the Public Health Service Hospitals until the local area health planning councils can conduct proper study under planning procedures essential to decisions of this magnitude. (The Secretary should provide the necessary cooperation and fiscal support needed in the conduct of this evaluation, including full access to public records and the support of Public Health Service personnel.)

3. Only after appropriate study, review, comment and evaluation by the local health planning councils, proceed to make a decision, based on fact, regarding the future role of the Public Health Service Hospitals.

In addition to fulfilling the dictates of good community based health planning, my suggested course of action would provide our local communities with adequate opportunity to prepare in advance for whatever outcome the study might conclude.

It is my considered opinion that if planning principles, including effective involvement of the citizens of our community, are to be achieved, the Secretary has no other rational course of action open to him than that which I have suggested. Further, the New Orleans Area Health Planning Council and most of the participating agencies of our community, I believe, would actively join the Council in support of this course of action.

THE MARYLAND HOSPITAL ASSOCIATION,
Lutherville, Md., March 5, 1971.

Mr. W. E. WILLIAMSON,
Clerk, Committee on Interstate and Foreign Commerce,
Washington, D.C.

DEAR SIR: We ask that you place this communication in the record of the Committee.

This is to express the Maryland Hospital Association's confidence in the work being performed at the U.S. Public Health Service Hospital, Baltimore, Maryland.

The institution is one of the most efficiently managed health care centers in our state. No other hospital among the Association's 55 members possesses a record or reputation for developing more innovative approaches to the delivery of hospital care services in Maryland.

Closure of the Baltimore U.S.P.H.S. facility will cause two major problems of concern to this association. One involves the almost certain lack of ready and available private hospital beds and services for government patients now treated at the U.S.P.H.S.H. Our other concern is the inability of local health facilities to hire the work force of the U.S.P.H.S.H., should it be closed. Since this group includes a great many highly qualified members of racial minorities, our concern in this regard is also voiced in the public interest of the Baltimore community.

We offer this statement in this manner, as we do not know at this time whether we will be able to appear before the Committee in person to express these serious concerns.

Yours truly,

RICHARD J. DAVIDSON,
Executive Vice President.

RETIRED OFFICERS ASSOCIATION,
Washington, D.C., March 11, 1971.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Retired Officers Association and the Retired Enlisted Association, composed of more than 132,000 members, strongly support House Concurrent Resolution 98. We strongly oppose the proposed closing or transfer of the remaining U.S. Public Health Service hospitals and outpatient clinics which are now providing necessary care for, among others, retired military personnel and their dependents.

The apparent plan to destroy the Public Health Service facilities, as evidenced by a campaign of attrition over the past several years, is both shocking and inconsistent. As we all know, in this great country today there is a shortage of medical facilities. Rather than diminish and liquidate them, we need to increase the number available.

Closing or transferring the remaining Public Health Service hospitals and clinics would be just one more example of the eroding away of the entitlements and benefits assured to military personnel for long-term service to their country.

The proposal also evidences an absolute lack of the compassion and feeling that is fundamental to any successful program of medical care and treatment for American citizens.

In what sounds like the old shell game, proponents of the plan say that savings will accrue therefrom. Upon close examination it is obvious that this statement is purely hypothetical, and refers to savings from what would have been costs to operate the facilities that will be shut down. The so-called savings would be offset by the costs of sending patients to private hospitals for which the Federal Government would pay the bills.

Mr. Chairman, we are heartened by your Subcommittee's response to this health care crisis.

Sincerely,

GEORGE F. MEYER, JR.,
Colonel, USA, Retired.

(Whereupon at 2 p.m. the hearing was adjourned.)

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